programs and social science theories of socialization. Social programs for support and development of those who cannot provide for themselves are supplements to or substitutes for the society's normal institutions for socialization. To be effective, these programs should exhibit the same characteristics and obey the same laws as effective interaction in the family, the school, and other socialization institutions.

In this review there was virtually no research on socializing processes in helping contexts. Perhaps the difficulty lies in the lack of support, both governmental and academic, for attention to problems of helping those who are poorly socialized.

This review did turn up a number of essays and methodological discussions and a few research reports which suggest a theory of purposive socialization programs. Three of these themes are noted: (1) the question of socialization into a state of dependency; (2) the problem of conceptualizing and measuring the socializing effectiveness of an environment; and (3) the question of the ability of labeling theory to explain processes of "desocialization." If "socialization" or "positive socialization" is development of useful and meaningful social relations, then one might also speak of negative socialization or desocialization.

The oldest dilemma of social policy for helping is whether adequate care for those unable to care for themselves tends toward socialization or toward desocialization, as in the "dilemma of the poor law," defined by Helen Witmer in her text *Social Work*. The socially inadequate were forced to enter the poorhouse if they wished to be helped. It was feared that help at home would be pleasant and destroy initiative to work. But the poorhouse by virtue of its barren unpleasantness tended to make them more inadequate, not less so. Normal social ties and role skills were lost. Because help had to be continued indefinitely, the policy defeated its own purpose. But many different helping programs seem to have desocializing effects.

Freud's essay on analysis "terminable and interminable" is another statement of the same problem. The relationship of the analyst is supposed to represent real life for the analysand and to improve the abilities of the analysand to deal with real life, but the relationship may become more satisfying than real life for the analysand and perhaps for the analyst, too. The relationship is continued indefinitely without regard to real life.

Another definition of this same problem is the notion of an intergenerational "cycle of poverty" among welfare families. Welfare critics, and occasionally social scientists, have sought to show that welfare is encouraging dependency by causing families to remain dependent on the Aid to Dependent Children check from generation to generation. While the accuracy of this claim has yet to be proved, the rationale is fairly easy to understand and seems plausible.

One way to operationalize the problem of desocialization for purpose of research is to investigate length of time under care. In the course of helping those unable to provide for themselves, there should be turning points and eventually a termination of help. Therefore, length of care or treatment may be a negative value because relatively longer continuation indicates dependency or desocialization. The logic of this argument overlooks the many persons unable to provide for themselves who require help and supplementation for an indefinite period. With this exception, the argument for length of help as an indicator of ineffectiveness of help seems to have plausibility.

A number of studies in this review adopted length of time receiving help as a dependent variable, as noted in chapter 2. Length of time under care or length of time out from under care was the most common outcome variable in evaluation research. But length of time under care was also the key dependent variable in a number of exploratory studies (79, 110, 114, 120, 225, 230, 251, 257, 258, 259, 268, 270, 309, 328, 357, 385, 399, 412, 413). In these exploratory studies the strategy was to identify cases of varying lengths of care or treatment, then to find factors to explain the variation.

In chapter 2, it was shown that the single factor most often associated with length of care was prior care. In other words, receiving help leads to more receipt of help. Recidivism among delinquents leads to more recidivism. The longer one remains in a mental hospital, the more likely one will remain in a mental hospital longer. The longer a child lives in foster care, the lower its probability of leaving foster care.

Is the finding that help leads to more help a significant finding or a tautology? This finding is neither circular nor trivial. In the studies reviewed here there were serious efforts to investigate other personal characteristics, properties of the helping situation, such as technique used and personal capabilities, to explain variance in length and amount of help received. None of these other factors proved satisfactory as an explanation.

The explanation of the finding that help leads to more help may be a significant process of desocialization. The kind of help offered and the context in which help is offered to those unable to provide for themselves may desocialize such persons rather than socialize or resocialize them. Thus, the mental hospital which is supposed to cure mental illness may actually cause mental illness. If mental illness is seen as deficiency in role performance and if the mental hospital is seen as a deprivation of opportunities for role performance, the finding would be both reasonable and significant. The main policy implication of this explanation would be to differentiate helping situations as to socializing effects.

There is an alternative and equally significant explanation for

the finding that help leads to help—there are people in our society who are unsocialized and who cannot be socialized. If these people cannot provide for themselves at any point in their lives, receipt of help or care at different times would be highly correlated. The main policy consequences of this explanation for the "help causes help" finding are that some percentage of the population is congenitally unfit. Only minimal help should be provided, at minimal cost, to provide safeguards for the normal majority against the unfit minority.

The scientific question is whether the "help causes help" finding is explained by characteristics of the persons being helped or by characteristics of the situation in which they are helped. Research which successfully distinguishes between chronicity as an effect of the helping situation and chronicity as an effect of personal characteristics is a crucial experiment for social science and social policy. The interpretation and comment on "absorbing situations" and other helping programs have been interpreted as supporting this latter explanation.

To develop a social science of the helping situation, better means of measuring situational properties are needed. What aspects of social interaction lead to successful socialization? What exactly is it about social relations which represent a higher quality of life? These questions concerning measurement of social interaction and the social context generally are another important area of development for social science and helping.

Measurement of amount and quality of social interaction is clearly in its infancy. Many reports were suggestive (7, 13, 22, 44, 48, 64, 65, 66, 67, 73, 74, 79, 83, 102, 104, 107, 111, 115, 124, 143, 146, 155, 163, 174, 177, 195, 213, 218, 219, 220, 225, 235, 237, 256, 262, 270, 272, 294, 298, 300, 303, 316, 320, 321, 322, 328, 346, 361, 370, 376, 386, 388, 400, 430, 433, 449, 451). Social context or social interaction was often a secondary concern. While a few investigators sought to measure social context, large scale study of the helpful social environment has not yet occurred.

One approach already noted is to use "amount of interaction" as a variable. Amount of interaction may be measured in clock time, frequency, or relative frequency. Two studies which examine the meaning of time to residents in traditional caretaking institutions, reviewed in chapter 3, bear on scientific study of social interaction because "time-passing" was a problem created by deficiencies in social interaction.

Other systems for observing social interaction have a normative basis. As noted in chapter 3, some reports used ratings of "reciprocity" or "positiveness" of social interaction. Still others rated activities of staff rather than activities of residents or clients. Many studies reviewed in chapter 3 and elsewhere, based on psychological

learning theory, examine the extent to which positive and negative social interaction events are consequent upon specific forms of behavior. These studies provide a classification for social interactions which identify "positive" as against "negative" behaviors, generally interpreted as approval and disapproval.

A third line of work which should contribute to a social science of helping—besides the work on chronic desocialization and on measurement of social interaction—is research on labeling theory. The basic premise behind labeling theory is that the label or name attached to a socially deviant person not only serves to describe that person's behavior but becomes a factor which itself affects future behavior. In the discussion of a possible theory of desocialization, it was noted that one explanation for the "help causes help" finding would rest on characteristics of the person being helped, and another explanation would rest on characteristics of the helping situation. Labeling theory poses still a third possibility: Desocialization occurs because of the response of broader society to certain behaviors.

Research on labeling theory is reviewed in chapter 3 (18, 40, 71, 94, 121, 122, 135, 136, 221, 249, 255, 287, 361, 371, 378, 390, 402, 417). Many of the research reports support the idea that socially deviating people are tagged with negative labels which reinforce a negative valuation by society. On the other hand, the specific effects of negative or positive labels on behavior are not shown. The detailed process by which people may cooperate with or interfere with the process of labeling has not been studied. At least, up to 1976, these studies were not carried out in relation to helping situations.

A third line of research is further examination of the natural history of the labeling process. A closely related line of research would be to investigate through time series or other adequate design whether the labels do in fact lead to differential consequences in terms of social interaction and social esteem.

Policy Challenges in Helping Those Unable to Provide for Themselves

At the beginning of this report it was noted that the dominant policy stance of this half century in helping those unable to provide for themselves is to favor small community-based situations. Large, socially isolated institutions are now considered undesirable. The literature revealed interest in obstacles to implementing community care.

One unsolved problem for community care is the tradition of second-class treatment in the community setting for those chronically unable to provide for themselves. This conclusion seems justified first from essays and research dealing with quality of help (23,

53, 70, 97, 187, 205, 230, 231, 232, 304, 366, 373), and second as an inference from the content of the literature in general. As noted in chapter 6, the primary negative bias concerning those who cannot provide for themselves may not be based on racial or ethnic lines but on chronic handicaps. Three particularly eloquent criticisms of new community-based programs come from persons with years of experience in the field of mental health: Cumming (97), Jones (205), and Hogarty (187). All three argue that new community programs continue to ignore the most seriously mentally ill. Presumably, the same argument may apply in such areas as mental retardation, the frail aged, and the seriously physically handicapped.

One cannot say that the charge—that alternative community programs ignore those target populations for whom they were specifically set up—has been proven by the literature covered in this review. On the other hand, the indictment is so frequently made and so serious that a major commitment of policy research seems indicated. Now that State mental hospitals, State training schools, State schools for the retarded, and other traditional institutions have become depopulated, where are those persons who formerly lived in those institutions? Is their welfare being served better in their present situation than in the traditional State institution? It would be a supreme irony if the current main policy trends, for example, community treatment and the legal "right to treatment" doctrine, did in fact conceal a new era of neglect for those most in need of help in providing for themselves.

A second and closely related policy question is that of the professionalization of helping and the deprofessionalization of alternative community programs. Many commentators who claim that community programs are failing the chronically handicapped tend to lay the blame on the helping professions rather than on public policymakers. Reports of research bearing on attitudes of professional helpers for those needing help (11, 17, 18, 71, 99, 167, 175, 229, 255, 261, 278, 281, 288, 337, 350, 361, 363, 379, 384, 404, 410, 429), as reviewed in chapter 4, tend to support that charge. A review of about 12 studies was summarized, indicating that attitudes of professionals toward those needing help were much like the attitudes of the general public in their negativism and lack of hopefulness. Another possible insight into professional attitudes was provided by some of the studies where decisionmaking by professionals was examined. An evaluation study of service to the aging by Blenkner et al. (46), reviewed in chapter 2, indicated that older persons at risk who received adequate social work services actually had worse survival rates than those who did not. The explanation suggested was that social workers tended to believe older people would be better protected by special placement. In fact, however, movement to residential care probably shortened life rather than lengthened

it. Other studies of decisionmaking supported stereotyped and overprotective decisions for placing persons under treatment (68, 125, 171). If treatment or help kept people from requiring further help, as suggested by studies reviewed above, professionals may be guilty of an overprotective attitude which unintentionally desocializes their clients and patients.

The need for new policy with respect to professionalization of helping was indicated in the reports of what were called "absorbing situations" (16, 20, 22, 43, 83, 118, 277, 293, 302, 409). In residential programs which were highly demanding and highly supportive, where very handicapped target groups were served, and where success was reported in efforts of social development, virtually all staff members were nonprofessionals. Either professionals are not willing to work with these target groups in practically oriented programs or their services may be too expensive to be used in intensive programs.

A major area of policy research is the question of the proper roles for helping professionals and their most efficient use in alternative contexts of help. Some successful programs, reviewed in chapter 1, show a pattern of program design and overall supervision by professional psychiatrists, psychologists, or social workers. Actual direct service was performed by aides or nonprofessionals who were trained on the job. Possibly the scope of small-scale programs to provide care for several hundred thousand persons unable to care for themselves can only be provided when scarce professional manpower is amplified in that way. In other words, perhaps helping professionals will have to assume a role of program design and program monitoring rather than a role of direct service.

Finally, there remains the puzzle of negative professional attitudes toward the most chronic and disabled of persons. Is there some reconceptualization of helping programs which would present them as a professional challenge and make them professionally attractive? Should a new profession be invented to work with severely and chronically handicapped persons? Should government regulations be adopted which require service to the most disadvantaged populations in return for Federal assistance in professional education?

Another area of policy development strongly suggested by many of the reports reviewed here is that of "coordination" or "interorganizational relations" (4, 36, 37, 57, 87, 98, 170, 192, 214, 240, 245, 252, 269, 296, 333, 360, 377, 421). As long as most persons unable to provide for themselves were cared for in State-administered institutional programs, this problem did not arise. With the attempts to create new settings for help or to insert chronically handicapped persons into existing community institutions, problems of coordination have become acute. This literature review supports the gen-

eral impression that there is indeed a problem of coordinating helping programs in different agencies under different auspices. Unfortunately, there was not enough development of research on this question to provide useful leads to further research.

The problem may be more sharply defined by specific examples. The Gatewood project (43) was carried out to move about 50 severely retarded State school residents into the labor market of New York City. The entire project was held up for 6 months because local offices of the State Division of Vocational Rehabilitation were unable to schedule routine psychological exams for that period. Another type of problem in coordination was noted in two pieces on daycare for the elderly (168, 227), summarized in chapter 1. Efforts to provide daycare as a secondary activity of medically oriented staff in a hospital were unsuccessful in both cases. Evidently the difference in orientation and the additional tasks were not accepted by staff, and the day patients were not accepted by 24-hour patients. The problem of coordinating medical and social programs is evident in a number of the reports (4, 36, 37, 87, 170, 214, 245, 252, 296, 301, 304, 333, 377). The medical setting specifically carries with it a structure of authority which may prevent effective social interaction required for social development. This problem is analyzed specifically by Glaser (147).

The basic problem of coordination at the case-helping level is access to needed service. Being a client of one program does not necessarily help one to receive service from another program and may even interfere. This particular problem is noted by a number of reports which are reviewed in chapter 5. The most common solution suggested, the device which is found repeatedly in program descriptions covered by this review, is the establishment of a "broker" function to help people get service (4, 240, 269). A number of terminologies and different mechanisms meet the problem of coordination at a case level, but they are not presented here since none appears to be based on a novel or penetrating analysis of the coordination problem.

It is not possible to point to systematic research on the problem of coordination. With the proliferation of smaller community-based programs having different organizational and professional affiliations, the problem is evidently becoming more acute. The main solution found in this review was to establish a new helping role centered on putting clients in touch with service programs, an unsatisfactory solution since its adoption leads helping efforts to become even more complex and specialized.

In summary, the policy questions are grave and appear not to be receiving adequate attention. It is ironic that the policy of deinstitutionalization based on a vague hope for more social integration of those unable to provide for themselves seems to have no supporting

social science guidance and no supporting structure of community service. Policy development in the Federal bureaucracy in the area of community care for those unable to provide for themselves includes such items as encouraging federally supported community mental health centers to obtain more State and local taxes and requiring comprehensive mental health centers to broaden their target populations. Regulations are being written for halfway houses, and preparations are being made for better health insurance coverage of mentally and chronically ill. Community psychiatric communities may be inspected and certified by the Joint Commission on the Accreditation of Hospitals. Associations of psychiatrists, psychologists, and social workers are active in seeking State and Federal legislative changes to insure that their professional members may be paid fees for providing case treatment. All of these policy developments are relevant to the problem but seem dismally inadequate in the face of the fundamental questions which remain unanswered. Where are the large numbers of chronic schizophrenics and mentally disturbed aged and severely mentally retarded who were formerly in State institutions but are not now in State institutions? In what social environments are they receiving help or care? Is the help they are receiving limited to a cash subsistence grant and some nursing or medical care? Are professionals in communities willing to provide social services or educational and recreational services to these chronically handicapped populations? Although these fundamental questions of policy are raised by this review, none of them is answered.

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2. Adams, Margaret E. First aid to parents of retarded children. *Social Casework*, 48(3): 148–153, 1967.
3. Adams, Stuart. A cost approach to the assessment of gang rehabilitation techniques. *Journal of Research in Crime and Delinquency*, 4(1): 166–182, 1967.

   A report is presented on use of cost-effectiveness methods in evaluation of Group Guidance, a detached-worker program in Los Angeles dealing with delinquent gangs. One hundred core members of three comparable gangs were the subjects. The Spartans had received full Group Guidance services; the Gavilanes had received partial services; and the Valiants received no services. Gang members' records were examined for correctional actions and services occurring over a 6-year period which was divided evenly into before- and after-treatment phases. The total period roughly covered the 14th through the 20th years of the members' lives. By use of auditors' estimations of the costs of correctional contacts, career correctional cost was determined for each boy over the 6-year study period. At the end of the 6-year period, a majority of the served or partially served boys were in "free" status, while a majority of the nonserved boys were in custody, parole, or probation. Among the 100 boys, mean correctional cost for the 6-year period was $6484. Total correctional costs of the Spartans were $270,427, with $169,592 before Group Guidance intervention and $100,835 after. Costs for the Gavilanes were $207,768, with $121,935 before and $85,833 after intervention. Costs associated with the Valiants were $180,240, with $70,416 in the before and $109,824 in the after-treatment phase. The Gavilanes showed a decline of 30 percent, and the Spartans decreased 41 percent while the Valiants' costs increased.

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These results present a convincing case for Group Guidance. (14 references)

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   Described is a program designed to enlist public health nurses as members of the community psychiatry team and to utilize their knowledge of an area and its people to help reduce the rehospitalization rate of patients discharged from the St. Louis County mental hospital. The program consisted of an intensive educational program for the nurses in the fundamentals of psychiatric theory, frequent communications between the nurse and the psychiatric staff, and continuing consultation for the nurses by the community psychiatry staff. The nurses provided services to the patient both before and after discharge. Prior to discharge, their duties were to assess the family, home, and community settings of the patient so that the hospital staff could better comprehend the patient's overall life situation. After discharge, the nurses gave supportive care to the patient and his family and kept the hospital staff informed about the patient's adaptation. In spite of problems related to securing medication and communications between the hospital and health department staffs, between October, 1969 and December, 1970, 66 new patients were referred to the public health nurses who made 220 home visits. In most cases, rehospitalization was prevented by public health nurse followups, and a substantial number of patients were referred to the hospital staff for diagnosis and care. (7 references)

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7. Alexander, James F., and Parsons, Bruce V. Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology*, 1973.

   A specific, short-term behaviorally oriented family intervention program for delinquent teenagers is described and evaluated. The program involved a set of clearly defined therapist intervention designed to assess the family behaviors that maintain delinquent behavior; to improve the family's communication patterns; and to institute a pattern of contingency

contracting in the family to modify maladaptive patterns and institute more adaptive behavior. The subjects were 46 families out of a total of 99 families referred by a juvenile court to a family clinic. An additional 40 families were randomly assigned to one of three comparison programs, a client-centered family group program (19), psychodynamic family program (11), and a no-treatment control (10). Upon completion of their programs, the first 20 treatment families, the first 10 client-centered families, and the 10 no-treatment controls were tested on family interaction tasks. Analysis of these data indicates that the families in the program demonstrated significant changes in the three family interaction measures compared to the other groups tested. In addition, an examination of juvenile court records indicates significantly reduced recidivism rates at followup for the intervention program families compared to the families receiving alternative forms of family therapy and the families receiving no professional treatment. (22 references)

8. Allen, James E. The silent observer: A new approach to group therapy for delinquents. *Crime and Delinquency*, 16(3): 324–328, 1970.
9. Allerhand, Melvin E.; Weber, Ruth E.; and Hang, Marie. *Adaptation and Adaptability: The Bellefaire Followup Study.* New York: Child Welfare League of America, 1966.

An evaluation is presented of the effectiveness of Bellefaire, a child treatment institution in Cleveland. The evaluation was based on measures of Casework Accessibility, Adaptability, Intrapsychic Balance, Role Fulfillment at Followup, and Situation and Stress or Support. Measures 1, 2, and 4 relate to behavior of the children in the institution, the others to the child or the situation within a year of discharge. Fifty boys were studied. Measures of the postdischarge situation were based on assessments of "Stress" vs. "Support" in both interpersonal and cultural areas. In general, the supportiveness of the situation was positively related to several role performance measures. The situation had an effect as an intervening variable. The main propositions tested in this study dealt with prediction of postdischarge role performance by role performance at admission and at discharge, role performance in the institution, and use of treatment. In general, it was found that role performance at admission was the best predictor of postdischarge role performance. For those children low on role performance at admission, the supportiveness of the situation was effective in predicting postdischarge role performance where treatment or earlier role performance measures were not.

10. Angrist, Shirley, and Dinitz, Simon. Home care for psychiatric disorders: Assessment of effectiveness. In: Roman, Paul M., and Trice, Harrison, M., eds., *Sociological Perspectives on Community Mental Health*, Philadelphia: F.A. Davis, 1974. 253 pp.

    Experimental and other research on readjustment of ex-inpatients and on community care is reviewed. The literature review suggests that the viability of community care is no longer really in question. Further research is needed, however, to ascertain conditions and consequences belonging to community care, readmissions to hospitals, actual levels of social functioning in the community, and costs to the family and community of maintaining the mentally ill person outside of the hospital. The origins of the community mental health movement are noted. Research on posthospital adjustment has identified social class, household composition, and chronicity as important factors. A brief review of research on success in preventing hospitalization leads to several observations. First, ongoing provision of drugs, psychotherapy, or social service is essential to prevent hospitalization. Second, home care is a considerable burden to families. Third, the question of burden is largely academic, since policy and program commitments to community care have already been made. To improve programs now starting, it is suggested that three criteria be more sharply defined and generally used. The three criteria are rate of rehospitalization, actual levels of functioning, and social cost to family and society. Implications of inattention to social cost are elaborated. Adequate home care programs require specially trained staff, comprehensive services including vocational, social, and health programs, accessible inpatient care, and community education.

11. Armor, David J., and Klerman, Gerald L. Psychiatric treatment orientations and professional ideology. *Journal of Health and Human Behavior*, 9(3): 243-254, 1968.

12. Arnhoff, Franklyn N. Social consequences of policy toward mental illness. *Science*, 188(4195): 1277-1281, 1975.

    A critique of the community mental health movement is presented. Public policy tends to ignore developments in biological psychiatry and the behavioral sciences and is predominately determined by short-range political expedience and the pressures of social reform. Common indexes of dehospitalization (length of stay, staff-patient ratios, recidivism, cost of care) are all subject to administrative manipulation. Studies of the effects of community treatment on family, siblings, and offspring, as well as the psychotic patient, are examined. These

studies indicate that community or home treatment is not necessarily superior either in its short-term or its long-term effects, and the burden on relatives and the community is in many cases intolerable. Several specific problems are noted: variance in quality of care of children by their parents, marked increase in birth rate among severely mentally ill, and the existence of a pool of patients who can never exist outside of institutions. (77 references)

13. Arnson, Alan M., and Collins, Ruby. Treating low-income patients in a neighborhood center. *Hospital and Community Psychiatry*, 21(4): 23-25, 1970.
14. Arthur, Gary L.; Donnan, Hugh H.; and Lair, Charles V. Companionship therapy with nursing home aged. *The Gerontologist*, 13(2): 167-170, 1973.

An effort to improve morale and adjustment of aged nursing home residents by providing voluntary companions is described. The subjects were 15 men and 15 women residing in a Phenix City, Alabama, nursing home. These 30 people were selected by the home's director and chief nurse. They had few visitors, were preoccupied with age and illness, and manifested little desire to live. One control and two experimental groups consisted of 10 subjects each. Each group had an equal sex distribution and a mean age of 77. Ten undergraduate students from Auburn University, five men and five women ranging in age from 18-29, with a median of 20, were volunteers. Pre-, post-, and followup data were obtained using the Life-Satisfaction Index A (LSI-A) to assess morale and the Revised Social Dysfunction Rating Scale (RSDRS) to assess changes in personal adjustment. Two types of visitation were used. In the "sustained therapy" group, each subject was visited by the same volunteer for 1 1/2 hours per week for 10 weeks In the "rotating therapy" group, each volunteer visited a different subject each week for the duration of the program. Significant improvement (p .02) in morale scales were found in patients receiving volunteer companionship as compared to the control group. The rotating group improved (p .005) more than the sustained group (p .06). At followup, the rotating group had improved significantly (p .001) in personal adjustment compared to the control group. The rotating group approached significant improvement when compared to the sustained group (p .07). Volunteers definitely had a positive effect. Yet, there was a higher morale improvement with the rotating group. It is therefore hypothesized that a variety of interpersonal experiences is more therapeutic than repeated similar experience. On followup, change in adjustment of com-

bined treatment groups approached significance (p .06). The treatment group appeared to continue improving after the study. (20 references)

15. Ash, Phillip. Pre-retirement counseling. *The Gerontologist*, 6(2): 97-99, 1966.
16. Baker, Bruce L., and Ward, Michael H. Reinforcement therapy for behavior problems in severely retarded children. *American Journal of Orthopsychiatry*, 41(1): 124-125, 1971.

    An experiment is reported which tested a reinforcement therapy program for severely retarded children. Participants in the program were 12 children ranging in age from 6 to 9 from a State school for the retarded. Six children were placed in an experimental living unit, while a control group of six remained on a regular ward. Matching of the experimental and control groups was based on preliminary behavioral observations and consultation with staff. The experiment was staffed by five attendants trained in methods of behavior observation, data recording, and reinforcement techniques. Programs involved the treatment of problem behaviors, training of self-help skills and the teaching of prenursery behaviors. Emphasis was on giving immediate rewards in a consistent manner, contingent upon a child's behavior. Results were measured by intelligence and developmental testing (Peabody Picture Vocabulary Test, Denver Developmental Screening Inventory [DDSI]), independent behavioral observations by trained observers, and records kept by project staff. Program children decreased more from baseline to treatment in problem behaviors ($t = 3.39$, $df = 10$, p .01) than control children. Four of the five program children not previously toilet trained were trained during the initial months of the program. The DDSI showed a significant improvement in program children ($X = 5.8$, $t = 1.57$, $df = 10$, p .08). The findings were thought to indicate the effectiveness of a total reinforcement therapy program for severely retarded children.
17. Baker, Frank, and Schulberg, Herbert C. The development of a community mental health ideology scale. *Community Mental Health Journal*, 3(3): 216-225, 1967.
18. Baldwin, Beverly Ann; Floyd, H. Hugh Jr.; and McSeveney, Dennis R. Status inconsistency and psychiatric diagnosis: A structural approach to labeling theory. *Journal of Health and Social Behavior*, 16(3): 257-267, 1975.

    The relationship between status inconsistency and the diagnosis of mental illness in psychiatric outpatient settings is explored. The psychiatric records of all diagnosed psychiatric patients (11,325) discharged through mental health centers and treatment clinics in a southern State, during the period

1968–1971, were examined. Data were obtained on the patient's diagnosis, marital status, occupation, welfare status, sex, age, race, and employment status. A status inconsistency index was constructed using marital status, occupation, and welfare status as the main components. Cross-tabulations of index values and the other variables were made, using percentages to compare groups. Status inconsistency of the patient showed the least explanatory power regarding diagnosis. Employment, occupation, age, and sex of the patients were moderately related to diagnosis. Patient's race was the single most powerful predictor variable. This finding was interpreted as a socially structured outcome mediated by the psychiatrist as a socialization agent.

19. Baldwin, Bruce A. Alternative services, professional practice and community mental health. *American Journal of Orthopsychiatry*, 45(5): 734–743, 1975.
20. Balthazar, Earl E.; English, George E.; and Sindberg, Ronald M. Behavior changes in mentally retarded children following the initiation of an experimental nursing program. *Nursing Research*, 20(1): 69–73, 1971.

    Described are the initial research findings of an experimental nursing care unit for severely retarded children which utilizes nurturant nursing principles, a setting as normal and homelike as possible, and a 24-hour-a-day supportive milieu in developing individualized programs based on behavior modification principles, particularly those of operant conditioning. A random sample of 16 severely retarded children showing self-descructive and often disturbed behavior were selected from the patients of the Central Wisconsin Colony for Retarded Children and divided into experimental and control groups with the control group remaining under usual care. Both groups were tested with the Central Wisconsin Colony Scales of Adaptive Behavior both before and about 4 months after the treatment. These results revealed significant experimental-control group differences on three social behavior factors: unskilled verbalization ($p < .05$), failure to respond to contact by others ($p < .05$), and passive response to contact by others ($p < .10$). There was a trend toward improved nonverbal communication. There were no significant differences in the behaviors listed under "resistive responses to others," "posturing," and "stereopathy or inappropriate response to others." (8 references)
21. Barresi, Charles M., and Coyle, Hugh G. Elderly services and industries: A pilot program of part-time employment for elderly poor. *The Gerontologist*, 12(4): 371–374, 1972.
22. Bartak, Lawrence, and Rutter, Michael. The measurement of

staff-child interaction in three units for autistic children. In: *Varieties of Residential Experience*, Tizard, J., Sinclair, I.; and Clarke, R. eds. London: Routledge and Kegan Paul, 1975. pp. 171-202.

Presented is a study of staff-child interaction in three specialized units for autistic children. The study was designed to evaluate different effects of varying approaches to special educational treatment. Three units were designed to contract "regressive" approaches centered on emotional needs against a structured teaching approach centering on perceptual and language skills. Unit A used regressive techniques with minimal attention to teaching of specific skills; this unit contained six boys and two girls with a mean IQ of 48. Unit B used a permissive classroom environment to combine special educational methods with regressive techniques; this unit contained ten boys and eight girls, with a mean IQ of 52. Unit C was a school solely for autistic children and structured education around perceptual, motor, and cognitive handicaps. This unit contained 18 boys and 6 girls, with a mean IQ of 66. The mean age of the children in all three units was 7-9 years. A series of 15-second observation periods, alternating with 15-second recording periods and consisting of 16 such alternations without breaks, were used to sample all unit activities and all unit staff. Teacher activities were recorded according to defined activities grouped as acts of instruction, playing with the child, acts of approval, and acts of disapproval. A second measure recording staff response, within 30 seconds, to a child's behavior was based on event sampling. Children's behavior was coded under four main headings: general, affect, language, and toileting, and each of these was subdivided into socially acceptable and deviant behavior. Interobserver agreement was tested and found to be satisfactory for the main components of each of the scales used. The results of the observational series showed that staff/child interaction in Unit A consisted mostly of playing, and that instruction was the main activity in units B and C. Event sampling of staff responses to children's behavior showed that in all three units acceptable behavior was followed by staff approval. In units B and C, deviant behavior was followed by disapproval; in unit A, deviant behavior was as likely to be followed by approval as by disapproval. Followup finding after 20 months and again after 4 years showed that, as judged by tests of reading and of arithmetic/mathematics, the children in unit C had made the most scholastic progress and those in unit A the least. The results suggest that an autistic unit with a high staff-child ratio and large amounts of specific teaching in a well-

controlled classroom situation is likely to bring the greatest educational benefits.

23. Beigel, Allan, and Feder, Samuel L. Patterns of utilization in partial hospitalization. *American Journal of Psychiatry*, 126(9): 1267-1274, 1970.
24. Beigel, Allan, and Feder, Samuel. A night hospital program. *Hospital and Community Psychiatry*, 21(5): 146-149, 1970.
25. Beisser, Arnold R., Models of helping and training for incapacity, *American Journal of Orthopsychiatry*, 43(4): 586-594, 1973.
26. Bell, Bill D. Mobile medical care to the elderly: An evaluation. *The Gerontologist*, 15(2): 100-103, 1975.

    Evaluation of a program for statewide health care delivery to rural aged to Arkansas is presented. MERCI (Multiphasic Examinations to Reduce Chronic Illnesses) began in November, 1973 with a Federal grant of approximately $125,000. Staff included a director, a project coordinator, a secretary, a registered nurse, a licensed practical nurse, a medical technician, and a driver/maintenance man. The unit traveled in a converted bus to those rural areas of Arkansas which were at least 20 miles from the nearest physician. The free examination included a short medical history, visual acuity and blood pressure measurement, urine and blood tests, and an electrocardiogram tracing. The exam lasted about 15 minutes. On an average day, the unit examined 30 to 45 patients. Unit personnel later went over each patient's file to determine whether a letter would be sent advising the patient to consult medical help. A copy of all medical data gathered by the unit would be forwarded to the physician of the patient's choice. In the first 6 months, the MERCI unit screened 2,738 people with a mean age of 69.5 years. Of those examined, 42.7 percent were men, and 57.3 percent were women. Seventy-six percent had family incomes of less than $3000 yearly. There were significant incidences of high blood pressure (31 percent), heart trouble (21.9 percent), and eye problems (17.3 percent). Referrals were necessary for 12.8 percent of those examined. The mean length of time since the patient's last contact with a doctor was 11.4 months. Whites tended to see their physicians more often than blacks. Blacks exhibited more serious medical conditions than whites. Lack of transportation, medical facilities, and personal finances were obstacles to health care. The project was used more often by whites (66.8 percent) than blacks (33.2 percent). In followup interviews, two reasons found for this were the mode of advertising and the "medical racism" found in rural Arkansas. Though an attempt is made to determine if the patients have seen a physician, no effort is made to contact

the physicians. Indications suggested that costs will stabilize at less than $20 per person. (18 references)

27. Bell, William G. Community care for the elderly: An alternative to institutionalization. *The Gerontologist*, 13(3): 349-354, 1973.
28. Bell, William G., and Olsen, William T. An overview of public transportation and the elderly: New directions of social policy. *The Gerontologist*, 14(4): 324-330, 1974.
29. Benney, Celia; Black, Bertram J.; Frank, Hilde; Besben, Sherman P.; and Lehman, Ethna. Facilitating functioning of mentally ill adults. *Social Casework*, 52(7): 420-431, 1971.
30. Bentz, William K., and Davis, Ann. Perceptions of emotional disorder among children as viewed by leaders, teachers, and the general public. *American Journal of Public Health*, 65(2): 129-132, 1975.
31. Bentz, W. Kenneth, and Edgerton, J. Wilbert. Consensus on attitudes toward mental illness, *Archives of General Psychiatry*, 22(5): 468-473, 1970.

Interviews were conducted with a random sample of 1,405 adult "general public" respondents, and a questionnaire containing the same schedule of questions was completed by 418 community leaders in rural counties in North Carolina and Virginia to learn about the information and attitudes of the public and community leaders about mental illness. The general public sample can be described as a highly rural and stable population representative of the universe in sex, race, and age. The respondents were poorly educated. The income of the sample was low. The community leader sample represented all the major areas of community life. Community leaders and the general public in this study were very similar in their attitudes about mental illness. A majority of both groups agreed that it is the most serious health problem in the country, that at least 10 percent of the people need treatment for some form of mental or emotional illness, that mental illness takes many forms with varying degrees of severity, and that all persons afflicted with mental illness do not exhibit the same behavioral manifestations. The members of the leader sample were much less likely than the general public sample to ascribe mental illness to hereditary, moral, or organic deficits. The leader group is different from the public in that fewer of them held the view that mental hospitals are needed in order to protect the community from the mentally ill (35 percent vs. 70 percent). Fifty-four percent of the leaders and 63 percent of the general public agreed that "it is usually better for the mentally ill person to receive treatment in the community than in a mental hospital."

32. Bentz, W. Kenneth; Edgerton, J. Wilbert; and Hollister, William G. Rural leaders' perceptions of mental illness. *Hospital and Community Psychiatry* 22(5): 143-145, 1971.
33. Berg, Sylvia K., and Hirsch, Carl. A successful model for community support of low-income minority group aged. *International Journal of Aging and Human Development*, 5(3): 243-252, 1972.

    A multifocus approach to work with low-income, minority-group aged in urban neighborhoods is presented. The program described—Model Cities Senior Wheels East—combined group work and community organization in an attempt to eliminate the personal vulnerability of individual members of the aged population through use of their political power to secure needed services on a permanent basis in their neighborhoods. This was an outreach program which dealt with critical personal problems of the aged in the target area. In the first year, community workers canvassed the total target area on a door-to-door basis and uncovered many cases of needy older people. The workers provided referral and advocacy services. In the first 9 months, 7,620 contacts with households were attempted or completed, and 460 elderly were served. Fifty-two agencies were utilized, and 1,591 followup contacts were made. Also in the first year, one staff member organized several neighborhood groups and established liaison with some existing groups. The program was considered a success. (13 references)
34. Berg, William E.; Atlas, Lucille; and Zeiger, Joan. Integrated home-making services for the aged in urban neighborhoods. *The Gerontologist*, 14(5): 388-393, 1974.

    The first year of a homemaking project with a range of integrated services for the elderly in an inner-city Milwaukee neighborhood is described. The parent agency of this homemaking service was Project Involve, a community-wide agency that dealt with the problems of the aged in Milwaukee through a variety of programs. In 1971, Project Involve contractually agreed to provide homemaking services to senior citizens living in the Milwaukee Model Cities neighborhood. The Milwaukee Model Cities neighborhood was a deteriorating, impoverished, and racially changing neighborhood which was once a working class area. Eleven percent of the area's population were elderly who tended to live on marginal incomes in homes they purchased years ago. The homes were quite deteriorated. Homemaking services began in July, 1971, with a staff of one director, two social workers, and twenty-five paraprofessionals, eight of whom were aged. At intake, an outreach worker assessed the client's specific needs. If homemak-

ing services were required, the case was assigned to the homemaking section. The supervisor then decided the specific services to be provided and arranged for scheduling of such services. The program offered home help and transportation on an as-needed basis. In the first year, the program received 199 requests for homemaking services and was able to provide services in 165 of these cases. The average length of contact per client was 8 months. Services involve an average of 4 hours per week or less. Approximately 10,000 hours were spent in providing services at a cost of $5.70 per hour. For about $100 per month per client, the program was able to furnish services necessary to the continued independence and self-sufficiency of these clients. Data show that 78.8 percent of the clients were women, 66.6 percent were white, and the mean age was 74. Clients received about $150 monthly through OAA or Social Security. At the end of the first year, 41.2 percent of the initial 165 cases had been closed, 42 percent because the client had moved to a nursing home or hospital or had died, 20 percent because the client no longer needed the services, and 18.8 percent because the family found alternative resources. The need for this type of service seemed to be greatest among the unattached, low-income elderly over 70 years of age. The program operated on the assumption that homemaking services should be available on a demand basis and that the ultimate judge of need is the recipient. (16 references)

35. Bergman, Joel S. *Community Homes for the Retarded.* Lexington, Mass.: Lexington Books, 1975.

A practical guide to the establishment and operation of small "community homes" for retarded persons is presented. The term "community home" is preferred to "halfway house" because of its implication of a homelike atmosphere where persons are prepared to move out into the community. The four contributors to this volume were the key agents in establishment of six homes in the Boston area, all located in cities of 20,000 to 30,000 and caring for a total of about 35 adults (four homes) and 14 children (two homes). Community citizens were organized, corporations formed, boards recruited, and so on. Financing of homes was through government payments and purchase of care. Experience indicated a cost of about $50,000 per home per year, or $6,000 to $8,000 per resident. A special problem was found in the all-or-nothing nature of disability assistance since part-time work made residents completely ineligible for supplemental security income. Population of homes came from State schools and community referrals. Children presented a number of special needs, but the basic format or homelike residence directed by a young houseparent couple

was still followed. The houseparent roles required discipline and warmth from the houseparent families and involved careful but natural management of sex roles, discipline, and teaching. The problem of preventing the reestablishment of institutional relations required much attention. Selection of houseparents as well as homes was a difficult process. The Adaptive Behavior Scale (ABS) was used to measure functioning and coping among residents, but change measures were not yet available. Behavior modification schedules using primarily social reinforcement and positive reinforcement were generally used by houseparents. Of the first 11 residents in the first home, two were back in State facilities, five living and working in the community, and four still in the home after 2 1/2 years. In the three other adult homes after only 8 months' experience, most of the residents were working in sheltered situations and living in the home, three residents had gone back to State facilities, and one was living in the community and working in a competitive employment situation.

36. Bergman, Simon. Facilitating living conditions for aged in the community. *The Gerontologist*, 13(2): 184-188, 1973.
37. Berkman, Barbara G., and Rehr, Helen. The "sick-role" cycle and the timing of social work intervention. *Social Service Review*, 46(4): 567-580, 1972.
38. Berleman, William C.; Seaberg, James R.; and Steinburn, Thomas W. The delinquency prevention experiment of the Seattle Atlantic Street Center: A final evaluation. *Social Service Review*, 46(3): 323-346, 1972.

A social service program experiment is reported. Substantial amounts of skilled social work service to predelinquent seventh grade boys did not reduce subsequent reports of problem behavior when compared to an untreated control group. Measures for problem behavior, interview schedules for parents and boys, and methods of case recording were developed. Encouraging results were obtained during a 3-year pretest. In the fall of 1964, all 421 boys entering seventh grade in two schools of a predominately black ghetto area were examined. The 120 boys with most frequent and serious problem reports from teachers and police were divided randomly between experimental and control groups. Three qualified social workers provided group work, casework, and community advocacy services to 52 boys and their families for about 2 years. Amounts of service provided were documented. Criterion measures were change over time in police and school reports of problems for each subject. Differences between experimental and control boys over a 3-year period were not significant and favored the control group. Labeling effects are excluded as an

explanation of the findings. Racial difference of the two groups and different attrition rates are the only apparent threats to validity, and these do not seem serious. Two questions are raised: Should intensive social services for such families continue to be supported? Are new and more system-focused intervention strategies needed?

39. Berleman, William C., and Steinburn, Thomas W. The value and validity of delinquency prevention experiments. *Crime and Delinquency*, 15(4): 471-478, 1969.

    Five major studies of delinquency prevention programs that were conducted in the open community among volunteer juvenile subjects are evaluated. All five studies concluded that the provision of a preventive service seems no more effective in decreasing delinquency than no service at all. The delinquency prevention experiments analyzed all provided social service to children who had not yet been judged delinquent and adhered to strict research protocol. In all five studies, there was little or no difference between control and experimental groups. The degree of exposure to service, however, was found to be very low: It ranged from less than one to slightly more than two contacts per month. Also, the researchers failed to report the facts of the service in sufficient detail to permit more than a gross evaluation of the quality of the service. Due to these two faults, the negative findings of past delinquency prevention experiments need not be accepted as a final assessment of the effectiveness of such services. (13 references)

40. Berry, K.L., and Miskimins, R.W. Concept of self and posthospital vocational adjustment. *Journal of Consulting and Clinical Psychology*, 33(1): 103-108, 1969.

41. Birenbaum, Arnold. On managing a courtesy stigma. *Journal of Health and Social Behavior*, 11(3): 196-206, 1970.

42. Birenbaum, Arnold. The mentally retarded child in the home and family cycle. *Journal of Health and Social Behavior*, 12(1): 55-65, 1971.

    Techniques developed to manage the social and personal strains of mothering a retarded child are reported. Coping techniques were investigated through semi-structured interviews with 103 mothers. Three major observations are suggested about maternal role adaptations. First, mothers emphasized expressive (emotional support) responses over instrumental (skill teaching) responses. Mothers preserved normal appearance by verbal assertion of conventional rules, such as "don't overprotect the child," while at the same time behaving very protectively toward the child. Second, mothers fitted the child into conventional routines adapted for the family in a way that preserved a social appearance of conformity. This

behavior could be called "routinization of disability." Third, these two methods of adaptation broke down as the child passed into the normal age of independence.

43. Birenbaum, Arnold, and Seiffer, Samuel. *Resettling Retarded Adults in a Managed Community.* New York: Praeger, 1976.

The results of an experimental program to resettle retarded adults from traditional institutions to a "managed community" in New York City are documented. Data came primarily from interviews with 48 of the first 63 persons transferred, at the time of transfer and twice more at intervals of 7 to 10 months. Besides presenting interview data, this volume summarizes the theory of "normalization" behind this program and the professional bureaucratic and political problems of its establishment. Observations are interpreted to indicate new insights on "normalization" and future research needs. The idea of "normalization" is for people unable to care for themselves to identify areas of competence, then impose training and expectations to stimulate and sustain "normal" levels of performance in those areas. The idea of a "managed community" is a small group of interacting persons forming norms and support mechanisms. Membership is voluntary, yet admission to the community and supervision of behavior are largely under control of its "managers" and not members in general. In March 1973, the first of 63 selected retarded adults were assigned to a residential facility, Gatewood, from three large State-operated facilities. The residents were mostly male, had a mean IQ of 50.8, were able to care for themselves in dressing, etc., and in many cases had had formal or informal "jobs" at the State schools. Their mean age was 33, and mean years of State school residence was 18. During its first 6 months, residents had to wait for vocational testing and Gatewood operated much like the State schools with residents and attendants assuming traditional roles. Later, two developments changed this pattern. The 48 who remained formed rules and norms which they imposed on each other. Second, most of the 48 were able to move out to the community for social and other services and most significantly to work in sheltered workshops. Data from interviews are cited to show statistically significant (Chi-square) changes in community participation, social interaction, and self-reliance. Among individual residents, differences in adjustment at Gatewood were not associated with IQ, sex, length of residence at State school, or behavioral problems at State school. Differences in cost were not examined. Future research might focus on the supporting network of services necessary to enable more "managed communities" to function.

44. Bjaanes, Arne T., and Butler, Edgar W. Environmental variation in community care facilities for mentally retarded persons. *American Journal of Mental Deficiency*, 78(429), 1974.

Studies of the behavioral environment in two board and care facilities and two home care facilities were reported. Significant differences existed in these facilities in patterns and characteristics of behavior. A different resident was observed during each of four observational periods in each facility. Behaviors were described under five categories: passing-natural; independent-dependent; spontaneous-planned-routine; structured-unstructured; or obligatory-discretionary. These categories of behavior were used primarily to describe activities of residents in order to distinguish between facilities that encourage behavior leading to development of competency and normalization as opposed to those that did not. The first two behavioral patterns were viewed as characteristics of the individual. The remaining three were considered indicators of the caretaker's involvement in the ongoing behavior of a given facility. There were significant differences in the way time was spent by retarded persons in different community care facilities, as well as differences in the amount of time spent on different types of activities. Such differences appeared to be functions of variations in environmental climates of each facility. The board and care facilities were closer to the objective of normalization and developing social competence. More behavior was independent in board and care facilities. The development of independent functioning and social competence appears to be related to the geographical location of the facility and the involvement of the caretaker in the ongoing stream of behavior.

45. Blenkner, Margaret. Environmental change and the aging individual. *The Gerontologist*, 7(2): 101-105, 1967.

Research evidence is discussed as relevant to the following hypothesis: There is a negative association between placement and survival among older persons which prevails even when their physical condition is held constant. A corollary of the main hypothesis is: If services to sick aged are primarily directed toward securing the needed care in settings other than the person's own home, the survival rate of the clientele will be lower than that resulting from a service which provides the needed care in the client's own home or from a program that makes no attempt to provide any personal care. A review of several studies shows a negative relationship between survival and institutionalization. Older persons admitted to institutions are at high risk during the first 3 months. A followup study of patients relocated because of the closing of

a chronic disease institution offered statistical evidence of a relocation effect on survival. For the first year following relocation, the death rate was significantly higher than the anticipated rate. The death rate in the first 3 months was three times that of the anticipated rate. The highest death rates following relocation had been found among persons suffering from brain syndrome, either chronic or acute. Functional or affective psychosis is linked positively to survival. At the Benjamin Rose Institute sample of 164 noninstitutionalized older people in need of protective services was secured in 1964–1965 from 13 social and health agencies serving the aged in Cleveland. The 164 were randomized into an experimental and a control group. Controls received whatever services were normally available in the community, while experimentals received a highly developed service directed toward maintaining them in their own homes if possible or placing them in protective settings. Preliminary findings showed that survival was negatively related to placement and that persons in a program that makes no attempt to provide personal services may do better than those in one providing a high level of individual care if that care is given in institutional settings. (14 references)

46. Blenkner, Margaret; Bloom, Martin; and Neilsen, Margaret. A research and demonstration project of protective services. *Social Casework*, 52(8): 483–499, 1971.

A program evaluation of personal social service for endangered aged is presented. The results were negative. A program of social casework and supportive services for noninstitutionalized older persons, mentally incapable of adequately caring for themselves, was monitored in a large city. A sample of 164 people was secured from several referring agencies over a 12-month period. The sample was predominately composed of persons over 75 years of age, female, white, native-born, nonmarried, and low income. As they were referred, each person was randomly assigned to either the experimental group (76) or the control group (88). Measures of each individual's competence, environmental protection, affect and effect on others, survival and institutionalization were recorded. Sources of data were participant responses to structured research interviews, observer ratings by the research interviewer, and clinical ratings by caseworkers for the service sample only. T-tests of these data over a 5-year period indicate that the physical and mental competence of both groups decreased significantly. Greater environmental protection was afforded in the experimental group. There was a positive but insignificant trend in regard to affect, with both groups showing increases in contentment and some decreases in behav-

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ioral disorder. There was a significant difference favoring the experimental group in "collateral stress," or adverse effects on others. The two principal negative findings were that the likelihood of institutionalization is increased by the service and that the survival rates of the experimental group were lower. It was concluded that the findings support discontinuation of the program.

47. Bolton, Brian, and Sommer, Patricia. Mode of address and patient satisfaction in rehabilitation: An experimental study. *Journal of Health and Social Behavior*, 11(3): 215–219, 1970.
48. Booth, Alan, and Babchuk, Nicholas. Seeking health care from new resources. *Journal of Health and Social Behavior*, 13(1): 90–98, 1972.

    The interpersonal information network employed by middle-aged and elderly individuals in reaching decisions regarding the use of health care facilities from new resources is examined. A sample of 800 noninstitutionalized adults 45 years of age and older residing in Lincoln and Omaha, Nebraska, were questioned as to their actions in the previous 12 months in consulting doctors they had never seen. The results indicated that interpersonal exchanges play a crucial role in decisionmaking regarding the use of health care facilities and that medical and paramedical professionals play a less critical role in influencing health care decisions than was expected. More specifically, the results indicate a pattern of activity. When counsel from others is sought, the individual usually seeks the advice of only one other person. Only under emergency conditions is the advisor likely to be a physician or someone associated with medicine. Advice from others is more likely to be sought when the individual is worried that his ailment may have adverse effects on his financial resources, family relations, and work. Individuals with greater interpersonal resources are likely to obtain the counsel of others. Acquaintances having personal experience with the health service in question are consulted when technical information is needed. Kinsmen who counsel clients are not generally knowledgable about health services, but serve in a supportive fashion. Regardless of the intimacy of the ties between client and advisor, influentials who provide specific information, evaluate previous medical care, propose diagnoses, and generally provide instrumental counsel are judged by the clients to be more influential than advisors whose counsel is primarily expressive in mode. (25 references)
49. Bord, Richard J. Rejection of the mentally ill: Continuities and further developments. *Social Problems*, 18(4): 496–509, 1971.

    Attitudes toward the mentally ill are reported, as learned

from responses to social distance scales and simulated case vignettes. Earlier research is supported in large part but these findings indicated that more importance should be attached to two characteristics of behavior, "perceived predictability" and "threat." A sample of college students (N = 350) was presented with case vignettes used by Phillips and others. Cases were evaluated as to degree of seriousness in the same order as previous studies: normal, compulsive, depressed, schizophrenic, paranoid schizophrenic. The "patients" in the vignettes were also identified according to help source and occupation. Help-source variation had less influence than in some earlier studies, which is interpreted as showing that college students did not require the help-source cue to respond. Where lower class occupations were ascribed to patients exhibiting threatening behavior, rejection was increased. These findings support the idea that social situation and status, as well as type of behavior, are important in determining reaction to mentally ill persons.

50. Boslow, Harold M., and Manne, Sigmund H. Mental health in action: Treating adult offenders at Patuxent Institution. *Crime and Delinquency*, 12(1): 22–28, 1966.

    Described is the Patuxent Institute, an institution which dealt with approximately 500 offenders judged to be "defective delinquents." After sentencing to a penal institution, a judge could refer an offender to Patuxent for evaluation. Based on the psychiatric report, a civil court could then find the offender a "defective delinquent," in which case he would be sent to Patuxent on an indeterminate sentence. The indeterminate sentence was seen as a motivating force to stimulate the patient to change. The institution provided psychotherapy, vocational rehabilitation, occupational therapy, and a therapeutic milieu. After psychiatric evaluation, the patient is placed in a graded tier system which rewards socially acceptable behavior. Patuxent was its own paroling board and could grant parole, holiday leaves, monthly leaves, live-in/work-out, and time-limited parole. Group therapy was encouraged. An outpatient clinic staffed by psychiatrists, psychologists, and social workers treated men on parole. (2 references)

51. Boudewyns, Patrick A., and Wilson, Alan E. Implosive therapy and desensitization therapy using free association in the treatment of inpatients. *Journal of Abnormal Psychology*, 79(3): 259–268, 1972.

52. Boudewyns, Patrick A. Implosive therapy and desensitization therapy with inpatients: A five-year follow-up. *Journal of Abnormal Psychology*, 84(2): 159–160, 1975.

53. Bourestom, Norman C. Evaluation of mental health programs

for the aged. *International Journal of Aging and Human Development*, 1(3): 187–198, 1970.

From a review of the literature, major trends and issues concerning mental health programs for the aged are evaluated. These trends fall into three main categories: (1) the scope and nature of the mental health programs; (2) increased attention to long-term residential facilities other than the mental hospital; and (3) development of community-based programs. Since community programs are poorly represented in the literature, they are not discussed. Persons 65 and over accounted for about 30 percent of mental hospital populations. Incidence rates of mental disorder among noninstitutionalized elderly seemed to be about 15 percent. The physical external factors were important in mental disorders of the elderly; treatment programs needed to be comprehensive in order to be effective. In mental hospitals there had been a shift away from traditional custodial programs to more active therapeutic or milieu therapy programs. Potential for rehabilitation of older patients was viewed more optimistically than in the past. Some mental hospitals had redefined their roles so that their functions resembled those of a modified community mental health center. The number of mentally ill aged in nursing homes exceeded the number in mental hospitals. Many more studies are needed, especially longitudinal and taxonomic research, to plan mental health programs for the aged. (38 references)

54. Boyajian, Levon Z. History strikes again: Two 20th century reform ventures. *Hospital and Community Psychiatry*, 24(1): 17–21, 1975.

Parallels in ideology and public policy are noted between the urban health centers movement after World War I and the community mental health centers movement 50 years later. Four striking parallels are traced: district or catchment area planning, preventive emphasis, community participation, and formal organization of health services as part of government. Also, both movements seem to have expired with periods of fiscal conservatism.

55. Bram, Howard B. Vacation and holiday guest program. *The Gerontologist*, 14(1): 29–30, 1974.

56. Brieland, Donald. A follow-up study of orthopedically handicapped high school graduates. *Exceptional Children*, 33(8): 555–562, 1967.

The employment status, social participation, self-feelings, and attitudes toward aspects of the school program of 41 orthopedically handicapped graduates of a residential school are examined. Each subject was administered by mail or by an interviewer—depending on the subject's location—a Hospital-

School Attitude Scale concerning the subject's attitudes toward various aspects of the school program, a schedule dealing with the subject's present status, a life satisfaction scale, and a schedule dealing with the subject's well-being. An examination of responses indicated that this study's findings concerning the employment status, marriage, social life, and intelligence of the subjects are consistent with the findings of earlier studies. Responses, showing subjects' attitudes toward the school program, indicated that (1) the medical and occupational therapy programs were liked best, and the vocational, social service, and food programs were liked least; (2) the longer the individual had been at the school, the less favorable was his attitude; (3) the longer the individual had been at school, the less he tended to want to leave it; (4) the overall attitude to the school was highly favorable; and (5) the outstanding recurrent theme was more independence and freedom for the students to better prepare for problems in the outside world. (8 references)

57. Brendes, Ralph C. Interstate supervision of parole and probation. *Crime and Delinquency*, 14(3): 253-260, 1968.
58. Brody, Elaine M. Intermediate housing for the elderly: Satisfaction of those who moved in and those who did not. *The Gerontologist*, 15(4): 350-356, 1975.

    Satisfaction of aged persons with special housing arrangements is studied through a quasi-experimental design. A sample of 87 applicants to the Philadelphia Geriatric Center's Intermediate Housing for the Elderly was divided into an experimental group—those who moved in—and two control groups. One control group included those moved elsewhere, and the other, those who did not move at all. Satisfaction with living arrangements was compared among the three groups. Intermediate housing is provided by the center for physically and behaviorally functional elderly and offers an emergency call system, shared social facilities, and building maintenance. All three groups were comparable in demographic characteristics, housing history, and personal satisfaction. After 6 months, those who moved into the center had improved in their overall satisfaction with living arrangements; their wish to move had dissipated to a much greater extent; and they had increased in enjoyment of social activities. (9 references)
59. Brody, Elaine M.; Klekan, Morton H.; Lawton, M. Powell; and Silverman, Herbert A. Excess disabilities of mentally impaired aged: Impact of individualized treatment. *The Gerontologist*, 11(2): 124-133, 1971.
60. Brolin, Donn. Value of rehabilitation services and correlates of vocational success with the mentally retarded. *American Journal of Mental Deficiency*, 76: 644, 1972.

61. Bronson, Edith P. An experiment in intermediate housing facilities for the elderly, *The Gerontologist*, 12(1): 22-26, 1972.

Reported is an experiment that began in 1965 under the auspices of the Philadelphia Geriatric Center (PGC) which bought two separate family dwellings in row houses and converted them so that each could accommodate several elderly women. Two different service patterns were employed. The first house had four individual rooms with the bathrooms, living and dining rooms, and kitchen to be shared. The house was fully furnished, and rent was $40 per month. Services offered without extra charge included weekly general housekeeping, maintenance, recreational and sheltered workshop facilities participation, and social service contact (limited to emergencies) with the social worker with whom the initial contact was made. Residents were selected on the basis of need for housing and ability to live in such a setting. Problems with this first house were inadequate screening of residents to insure congenial matching, four women sharing one kitchen, and coordination of several social workers. In the second house, more attempts were made to match potential residents and to make the building more appropriate. The house was remodeled into three efficiency apartments, each furnished and with a bedroom and kitchen unit. The living room was shared. Services additional to those offered in the first house were weekly linen service, one meal per day supplied by the PGC and delivered frozen, and one social worker for the house to provide limited supervision and services. Regular monthly contact was maintained with the social worker. Rent was $85 per month or $65 for those receiving OAA. Supportive interest of relatives was found to contribute to the success of this type of living arrangement. The second arrangement worked well; the first house was replaced in 1969 with one modeled after the second house.

62. Brook, Bryan D. Crisis hostel: An alternative to psychiatric hospitalization for emergency patients. *Hospital and Community Psychiatry*, 24(9): 621-624, 1973.

A short-stay residential program to prevent psychiatric hospitalization is described. When all 49 emergency patients admitted to a "hostel" operated by Fort Logan Mental Health Center during its 5 months of existence were compared to the last 49 admitted to the inpatient crisis unit before the hostel opened on 13 outcome measures, only two measures showed a difference. The hostel patients had only one readmission after 6 months, compared to six for the control group. But the hostel group showed less remission of symptoms after 1 week and after 6 months. The difference in symptoms could be due to

much greater use of drugs in the control group. The idea behind the hostel program was to avoid family scapegoating of its "sick" member and also to avoid extrusion of the patient from his normal roles. A house near downtown Denver was rented in late 1970 to accommodate four patients. Minimal supervision and help with meals were provided by a nurse and by neighbors, all unpaid. When a patient dangerous to himself or others was admitted, Fort Logan staff member stayed at the hostel as necessary; other staff members spent time there to promote a pleasant social atmosphere. Most of the 49 admittees were severely ill. Almost half were rated as high suicide risks. Seven of the 49 were transferred to an inpatient unit to provide more structure. Half of the admittees were schizophrenic and the others divided between severe depression and alcoholism or some adjustment problem. Ages ranged from 17 to 62, with a mean of 32.7. Social system intervention was the primary treatment. Psychotherapy and medication were also used. Residents were expected to help maintain the house, socialize as they felt able, and return to their jobs or families within 1 week. The mean stay was 5.75 days. Operating costs of the hostel and two nearby "backup" beds averaged only $140 per month. The Fort Logan hostel was discontinued after 5 months because of a cut in State funds.

63. Brostoff, Phyllis M.; Brown, Roberta B.; and Butler, Robert N. The public interest: Report No. 6: "Beating up" on the elderly: Police, social work, crime. *International Journal of Aging and Human Development*, 3(4): 319-322, 1972.

64. Brown, Julia S. Levels of patient interaction on psychiatric wards: Some relevant variables. *Human Organization*, 30(4): 367-380, 1971.

Six properties of the psychiatric treatment setting are examined for their effect on the amount of patient interaction. Evidence from past research studies and data gathered through observations of patients' psychiatric ward behaviors were utilized to examine the effects on social interaction of (1) the extent to which patients are expected to engage in social interactions; (2) the extent to which members of the groups (both staff and patients) are rewarded for interacting with patients; (3) the proportion of the group that consists of persons who, because of their personal characteristics, are likely to interact frequently; (4) the size of the group; (5) the relative proportion of staff to patients; and (6) the extent of status differences and social distance between staff and patients. The evidence indicates that patient interaction is greater to the extent that the need for patient interaction is stressed; that patients and staff are rewarded for interacting with patients;

that the patient population is not disproportionately selected from among the aged, severely disturbed, or individuals just admitted; and that nonpatients mingle with patients; and differences in rank and authority between staff members and patients are minimized. (53 references)

65. Buckey, Harold M.; Muench, George A.; and Sjoberg, Bernard M. Effects of a college student visitation program on a group of chronic schizophrenics. *Journal of Abnormal Psychology*, 75(3): 242-244, 1970.

66. Buehler, R.E.; Patterson, G.R.; and Furniss, J.M. The reinforcement of behavior in institutional settings. In Moos, Rudolf, and Insel, Paul M. eds. *Issues in Social Ecology: Human Milieus*, Palo Alto: National Press Books, 1974.

Three studies which identify behavioral processes associated with shaping and controlling behavior in a peer group of delinquent adolescents are reported. The authors hypothesized that within the institutional setting, the majority of social reinforcers are provided by the peer group and not by the staff. In the first study, 15 2-hour observations by a single observer were made in a detention home for delinquent children. Accounts of responses reflecting delinquent value systems and responses corresponding to social norms were made. The data showed 70 percent positive reinforcement for delinquent behavior. In the second study, a method for observing and measuring interpersonal communication behavior in terms of four postulated levels of communication was used. The four levels of communication were biochemical, motor movement, speech, and technology. Each of the four levels had subcategories defined in terms of observable movement on the part of a person during interpersonal transactional episodes. The unit of measure was a 2.5-second time interval. Twenty-four girls from a State institution (12 from less restricted and 12 from more restricted cottages) were observed during their leisure time in cottage. Subjects' age range was 13.5-18 years, and length of institutionalization varied from 2 to 30 months. Each subjects' interpersonal transactions with peers were observed for two 25-minute periods on two different days. Observed behavior lists were coded by two independent judges for level of communication, whether the act was in accordance with delinquent or socially appropriate norms and peer response. Responses were classified as positive reinforcements if there was an indication of attention or approval given the subject by peer or peers and as punishments if the peer response was disinterest or disapproval. Results showed that on all sample cottages the reinforcement of delinquent responses by peers occurred more often (p .001) than the punishment of

delinquent responses and that the peer group punished socially conforming behavior more frequently (p .01) than they rewarded such behavior. The third study focused on peer group behavior and the reinforcement contingencies dispensed by staff members. Behavior observations were made in a single cottage of the same State institution for girls used in study 2. A sample of six subjects was selected randomly for daily observations. The observations included two 1-hour group meetings each week conducted by the senior author and attended by staff and 24 resident girls. The observer focused her attention on the interpersonal transactions on the part of the six subjects, including their transactions with staff members. Individual behavior was coded in terms of communication and reinforcement categories and was combined with behavioral data from each of the six subjects' case folders to develop a behavioral diagnosis for each subject. The behavioral analyses were used to draw up treatment programs for each subject. Observed transactions between staff and girls were not as frequent as transactions among peers, but the data showed that staff members tended to reinforce and to punish indiscriminately.

67. Bullington, Bruce; Munns, John G.; and Geis, Gilbert. Purchase of conformity: Ex-narcotic addicts among the bourgeoise. *Social Problems*, 16(4): 456–463, 1969.

An experiment is reported in which ex-addicts are paid to do social service work with other addicts to see whether the ex-addicts would adopt middle class values and lifestyles. This experiment was partially successful. A program of street outreach, counseling, and job referrals with addicts and their families was established in 1967 in a California community, predominately Mexican-American. Ex-addicts were paid $600 per month as workers on the project. The 31 ex-addicts still working on the project after about 1 year of operation were interviewed in depth and project field notes examined. Ex-addicts adopted middle class dress in large part, adopted higher living standards, and 19 reported higher debts; but adoption of middle class values was uneven. An unexpected finding from the interviews was that as many reported having had higher incomes previously from illegitimate sources as reported having had lower incomes. Workers' exposure to a new professional role system seemed to introduce more significant changes than simply the higher income. Ex-addicts learned new social skills, made contacts to permit future opportunity, increased their self-esteem, and in most cases decided to stay in social service work. However, part of the project purpose was to keep the workers marginal, the better

to deal with addicts. Thus the workers occupied a marginal role with many ambiguities and in addition were exposed every day to lower-class pressures. The outcome therefore was still in doubt.

68. Burt, Marvin R., and Balyeat, Ralph. A new system for improving the care of neglected and abused children. *Child Welfare*, 53(3): 167-179, 1974.

69. Butler, Robert N. Public interest report No. 18—We should end commercialization in the care of older people in the United States: Some thoughts. *The International Journal of Aging and Human Development*, 7(1): 87-90, 1976.

An essay is presented favoring both the decrease of commercialization in the care of old people and its replacement by nonprofit social utilities. Social utilities are defined as organizations under governmental regulation whose purpose is the delivery of essential human and personal services. This concept is based on public utilities which are businesses placed under governmental regulation because they provide essential services or commodities. The owners of such utilities are influenced by the fact that permits or licenses must be obtained from governments. Rates and profits are also regulated. It is hoped that a social utility, besides changing regulation and financing practices, would lead to basic structured and functional reorganization in the delivery of care to old people. The present nonprofit community organizations for the aged could be the nucleus of this change. The systematic diversion of about half of Federal money now going to commercial homes through Medicare and Medicaid to presently existing nonprofit homes is suggested. Fundamental changes are needed in the financing, regulation, and delivery of social and health care to old people. The social utilities model may be an appropriate structure to achieve these goals.

70. Butterfield, E. Some basic changes in residential facilities. In: Kugel, R.B., and Shearer, A., eds. *Changing Patterns in Residential Services for the Mentally Retarded*, President's Committee on Mental Retardation, 1976.

71. Caetano, Donald F. Labeling theory and the presumption of mental illness in diagnosis: An experimental design. *Journal of Health and Human Behavior*, 15(3): 253-260, 1974.

72. Caffry, Eugene M.; Jones, R. Douglas; Diamond, Leon S.; Burton, Eleanor; and Bowen, William T. Brief hospital treatment of schizophrenia—early results of a multiple hospital study. *Hospital and Community Psychiatry*, 19(9): 282-287, 1968.

Effects on different types of treatment modalities on 203

patients from 13 State psychiatric hospitals are reported. On admission to one of the State hospitals, patients were assigned in rotation to one of these groups: Group A received normal hospital care with discharge at the physician's discretion and normal aftercare with usual social and psychiatric contacts; Group B received intensive treatment aimed at discharge on the 21st day, followed by a special schedule of aftercare visits and outpatient treatment of 1 year; and Group C received normal hospital care with discharge at the physician's discretion followed by special schedule of aftercare visits and outpatient treatment for 1 year. In all groups, patients were terminated from the study if not released from the hospital within a year after admission. Progress of the patients was assessed by Inpatients Multidimensional Psychiatric Scale (IMPS), the Katz Adjustment Scale (KAS), and a social worker's home visit inventory which the study group developed. All three groups were found to have equal initial levels of pathology. All three groups showed significant reductions in symptoms of excitement, hostile belligerence, paranoid projection, grandiosity, perceptual distortion, anxious intropunitiveness, retardation, motor disturbances, and conceptual disorganization within 3 weeks of admission to the hospital. Group C, whose members had received an unlimited time of inpatient care and a year of programed aftercare, produced the fewest number of readmissions followed by Group B. All three groups showed comparable variations in length of inpatient stay and time spent out of the hospital before readmission.

73. Clabert, Donald R., and Baltzer, Susanna. Home management in a comprehensive preschool program for hearing impaired children. *Exceptional Children*, 34(4): 253–258, 1967.

A home management program for preschool hearing-impaired children is described. The program is based on oral communication involving multisensory stimulation, with emphasis on developing the child's sense of hearing. The methods employed to influence the home environment range from simply telling the parent what to do, through lectures and discussions with groups of parents, a lending library or appropriate books, group guidance sessions, to actual intervention by a professional in the home. During the home visit, ranging from 1 hour to several days, the professional observes the everyday activities of the family and makes suggestions, based on these observations, for associating language development with these everyday activities of the family. Although the home visit program has a number of disadvantages in the areas of personnel allocation and funding, the advantages such as individualized program and treatment in the home

environment are believed to far outweigh these problems based on previous experience. The use of home visits in a home management program is encouraged. (0 references)

74. Calkins, Kath. Time: Perspectives, marking and styles of usage. *Social Problems*, 17(4): 487-501, 1970.

The meaning of time to patients in a rehabilitation center and their use of time are explored. The observations of patterns of use of time are useful for understanding how people structure their everyday lives and also give some insight on the experience of being a patient in 24-hour care. Fifty chronically ill patients in a physical rehabilitation center were observed, and time records were kept. The staff of the center held a "linear mechanistic" view of time, representing progress toward goals. The patients represented a variety of deviating and handicapping conditions and tended to view time in "cyclical" terms as progressing from crisis to crisis, without clear sequences. Findings are presented under two headings: methods to mark time and styles of using time. Patients who were improving physically often marked time around their rehabilitation. Others marked time by daily routine or by television programs. Long-term patients tended to mark time by admission and discharge of other patients or even by past events. Some patients were nearly unoriented to time—especially older long-term patients on drugs—and unusual events or family visits seemed their only markers. As to using time, six styles are identified: passing time, waiting, doing time, making time, filling time, killing time. The last three are of special interest for the treatment regimen. The time maker adopts a personal routine where time is valuable and is "used." Time is made in linear fashion, cognate to the staff perspective. Time making often degenerated to other styles if no recognition was received. Time fillers followed the staff cues and were oriented to the outside world but spent much of their day casually. Time fillers viewed themselves as exchanging their attendance at the center for a specific benefit. Time killers were persons who sought deviating or disrupting activities as a way to make their stay at the center bearable.

75. Cannon, Mildred S. *Halfway Houses Serving the Mentally Ill and Alcoholics*, National Institute of Mental Health. DHEW Pub. No. (ADM) 76-264. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1973.

A survey of 806 halfway houses serving mentally ill and alcoholic persons is reported. The houses were contacted initially with a mailed questionnaire. Those that did not respond to the mail queries were contacted by telephone and completed a shortened version of the mail questionnaire. For

analysis, the halfway houses were grouped into categories based on primary population, group served, and whether they served short-stay or long-stay residents. Houses in which 50 percent or more of the residents stayed less than 6 months were considered transitional, and those in which 50 percent or more of the residents stayed 6 months or longer were nontransitional. Two hundred and nine houses served primarily mentally ill persons, and 597 served primarily alcoholic persons. Sixty-two of the psychiatric houses were nontransitional, 78 were transitional, and length of stay was unknown for 69. For the alcoholic houses, 134 were nontransitional, 390 were transitional, and length of stay was unknown for 73. For psychiatric houses 2 percent had been operating 20 years or more as of October 1973, the median number of years in operation was 5.4, 70 percent were located east of the Mississippi River, and 96 percent were located in urban areas. For alcoholic houses, 4 percent had been operating 20 years or more as of October 1973, the median number of years in operation was 4.4, 46 percent were located east of the Mississippi River, and 94 percent were located in urban areas. Eleven States reported no psychiatric houses, and one State identified no alcoholic houses. Twenty-six percent of the psychiatric houses and 33 percent of the alcoholic houses were licensed as halfway houses; 29 percent of the psychiatric and 41 percent of the alcoholic houses reported not having any type of license. Fifty-nine percent of the psychiatric houses and 90 percent of the alcoholic houses were owned by nonprofit organizations. Median bed size for the psychiatric houses was 17, and for alcoholic houses was 18. Average annual expenditure for psychiatric houses was $73,000, and for alcoholic houses $42,000. The largest sources of funds for psychiatric houses were State and local government programs (37 percent) and patient fees (33 percent). For alcoholic houses, patient fees provided 32 percent of the funds, the Federal government provided 24 percent, and State or local government provided 23 percent.

Psychiatric houses had an average of 12 employees (7 full-time, 3 part-time, and 1 volunteer) and alcoholic houses had an average of 6 employees (4 full-time, 1 part-time, and 1 volunteer). Sixty-six percent of psychiatric facilities accept residents without regard to sex, and 66 percent of alcoholic houses restrict admission to males only. Psychiatric houses had an occupancy rate of 86 percent and 47 average annual admissions. Alcoholic houses had an occupancy of 77 percent and 125 average annual admissions. Males comprised 54 percent of total residents of psychiatric houses and 88 percent of alcoholic houses. Ninety percent of all psychiatric house residents

had been previously hospitalized as compared to 30 percent for all alcoholic house residents. Forty percent of residents leaving both psychiatric and alcoholic houses moved into independent living arrangements in the community.

76. Cantrell, Robert P., and Cantrell, Mary Lynn. Preventive mainstreaming: Impact of a supportive services program on pupils. *Exceptional Children*, 42(7): 381-386, 1976.
77. Carey, Jean Wallace. Senior advisory service for public housing tenants. *The Gerontologist*, 11(3): 264-267, 1971.

    A neighborhood-based demonstration project staffed by in-service trained workers of mature years giving outreach, information, advocacy, and referral services under professional supervision is described. This 2-year demonstration called for the stationing of four service workers, one in each of four low-rent public housing projects in the South Bronx. The four housing projects housed almost 1,000 men and women aged 60 or above out of a total population of some 13,000. These effects are measured by responses to pre- and post-service interviews of randomly selected populations of the four served housing projects and two other control projects located nearby. In all, 87 percent of the target population was reached in the 2 years of the project. The number of problems voiced by tenants came to 1,986. Inability to make use of resources independently, physical health, and insufficient funds made up 79 percent of the problems reported. A total of 3,687 services were rendered. The program had a measurable impact on maintaining emotional and physical functioning, but had less effect on social functioning. The program encountered serious deficiencies in community services. (17 references)
78. Caro, Francis G. Integration of evaluative research and social planning roles: A case study. *Human Organizations*, 33(4): 351-358, 1974.
79. Carpenter, James O., and Bourestrom, Norman C. Performance of psychiatric hospital discharges in strict and tolerant environments. *Community Mental Health Journal*, 12(1); 41-45, 1976.

    The relationship between the tolerance of deviance by significant others and select performance measures among 78 older ex-mental hospital patients is investigated. Most of the patients had been diagnosed as having schizophrenia and had been in the hospital for an average of 17 years. All patients had been actively engaged in a program of milieu therapy prior to their community discharge. Information about differential tolerance of deviance was collected through interviews with the significant others of patients, using items which call for a description of symptomatic behavior. Responses were then

combined into three levels as being "highly tolerant," "moderately tolerant," or "essentially intolerant" social environments. Questions asked of significant others and patients themselves concerning the patient's community tenure, social participation, life satisfaction, and level of instrumental performance were used to ascertain post-hospital outcomes. Whereas 34 percent of patients in low-tolerance settings returned to the hospital in the year following release, this was the case for only 13 percent of those in highly tolerant environments. These data suggest the importance of tolerance of deviance of significant others for the community tenure of patients ($x^2 = 5.0381$, p .05). Patients remaining in the community after 12 months in a low-tolerance environment had the highest social participating score. Those in the high-tolerance settings had the lowest scores, while those in moderate-tolerance environments had intermediate scores. These data suggest that the high demands for socially appropriate behavior in low-tolerance settings may be reflected in higher social performance levels among ex-patients ($F = 4.116$, p .025). A comparable picture emerges with respect to instrumental performance, although the differences are not statistically significant. The relationship between differential tolerance of deviance and the functioning of ex-patients in the community 1 year following discharge do not appear to reflect merely the return of low-score patients to the hospital. The social and instrumental functioning scores of patients returning to the hospital are very similar to those of ex-patients remaining in the community. Moreover, tolerance of deviance and the ages of discharged patients are not related, and sex, length of hospitalization, and education did not differentiate the performance and life satisfaction levels of discharged patients remaining in the community.

80. Carroll, Anne Welch. The effects of segregated and partially integrated school program on self concept and academic achievement of educable mental retardates. *Exceptional Children*, 34(2): 93–99, Oct. 1967.

The effects of segregated and partially integrated school programs upon the self-concept and academic achievement of educable mental retardates (EMR) are compared. A group of children (39), who were of elementary school age, had IQ scores between 60 and 80, and had no previous experience in any special education program, were drawn from the five major school districts of suburban Denver. These children were assigned to one of two groups: partially integrated (12 males, 7 females) or segregated (13 males, 7 females). The partially integrated group spent 1/2 day in a regular classroom and the other half in a special class, while the segregated group spent all day in a

special class. Each of the two groups was administered a battery of tests designed to measure the child's self-concept (Illinois Index of Self Derogation) and academic achievement (Wide Range Achievement Test) at the end of the 1st month and again after the 8th month of schooling. Additional personal data for each child were obtained from their teachers. The results indicate that EMR children in a segregated setting show less improvement in their self-concept than EMR children in a partially integrated setting. Significant improvements in academic achievement were registered only in the area of reading for EMR children participating in the partially integrated program. (13 references)

81. Chaffin, Jerry D.; Spellman, Charles R.; Regan, C. Edward; and Davison, Roxana. Two followup studies of former educable mentally retarded students from the Kansas work-study project. *Exceptional Children*, 37(10): 733–738, Summer 1971.

    The results of two followup studies conducted to evaluate the efficacy of a high school work study program for educable mentally retarded individuals are examined. A vocational-educational plan for on-the-job training and classroom instruction was developed for each individual. Goals were to eliminate behaviors inconsistent with work, teach specific skills important for a given job, and initiate instructional programs to develop desirable work habits and attitudes. In the final phase, students were required to work full time in the competitive labor market. This program was evaluated by comparison of 30 students participating in the program with 30 similar students who did not. An initial followup indicated that 92 percent of the experimental group had achieved satisfactory vocational adjustments, while only 68 percent of the control group had. Followup interviews 2 years later indicated that students who had participated in the program more frequently were high school graduates, held their jobs longer, and earned more money than the students from the control group. (15 references)

82. Charles, Don. D. Effect of participation in a pre-retirement program. *The Gerontologist*, 11(1): 24–28, 1971.

83. Chien, Ching-Piao, and Cole, Johathan O. Landlord-supervised cooperative apartments: A new modality for community-based treatment. *American Journal of Psychiatry*, 130(2): 156–159, 1973.

    The Cooperative Apartment Program at Boston State Hospital, a landlord-supervised community residential treatment modality, is described and initial results of the program are presented. Local landlords were recruited and their competence evaluated. Under the care and supervision of the

landlord-supervisors, the patients were responsible for such routine chores as cooking, housekeeping, shopping, and laundry. The landlord was to be actively supportive in the beginning by providing meals and assistance to the tenants but to work gradually toward having them care entirely for themselves. Patients handled their own budget. Those without financial resources received Disability Assistance. Patients were supervised by the landlord and the Cooperative Apartment Team, which included a psychiatrist, a social worker, an occupation therapist, and a nurse. The team visited each apartment at least once a week. Patients either worked or participated in the hospital's daycare program. Between December 1967 and May 1972, 186 homeless patients, mostly chronic schizophrenics, were placed in 35 cooperative apartments. Only 33 of these patients were readmitted to the psychiatric hospital. This suggests that more than 80 percent of such homeless patients who, because of lack of income or social resources might otherwise have been continuously confined in the institution, could be successfully placed in the community. The average annual cost per patient was $2183, about one-fifth of the cost for hospitalization. Evaluation of the program revealed a high degree of satisfaction on the part of both the patients and the caretakers (landlord-supervisors and hospital staff).

84. Chigier, E., and Chigier, Miriam. Attitudes to disability of children in the multi-cultural society of Israel. *Journal of Health and Social Behavior*, 9(4): 310-317, 1968.
85. Christie, Nils. Temperance boards and interinstitutional dilemmas: A case study of welfare law. *Social Problems*, 12(4): 415-428, 1965.
86. Claghorn, James L.; Johnstone, Edwine E.; Cook, Thomas H.; and Itschner, Lorri. Group therapy and maintenance treatment of schizophrenics. *Archives of General Psychiatry*, 31(3): 361-365, 1974.

    The efficacy of treatment combining group psychotherapy with psychotropic medications is assessed for 49 individuals diagnosed as schizophrenic. Study participants were randomly assigned in a double-blind manner to one of four treatment regimens; each group received either thiothixene or chlorpromazine in conjunction with either weekly group therapy or no psychotherapy; duration of treatment was 6 months. A single psychotherapy group included patients receiving the two drugs. Group procedures tended to be structured, with emphasis on the problems and tasks of daily living. Patient evaluations were made prior to treatment and at monthly intervals thereafter. At each monthly visit, a global

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assessment of the degree of improvement was made by the psychiatrist, the Brief Psychiatric Rating Scale (BPRS). In addition, the Interpersonal Diagnosis of Personality, consisting of the Minnesota Multiphasic Personality Inventory (MMPI), the Interpersonal Check List (ICL), and the Thematic Apperception Test (TAT) was administered at pretreatment and termination. For each measure in the Interpersonal Test Battery, raw test scores were converted to scores on dominance and affiliation dimensions by various means, and these scores were then converted to standard scores. The interaction of these two dimensions gave a global measure of the social desirability of behavior. The BPRS data were subjected to a mixed model analysis of variance. There were no significant differences between groups in any of the analyses. The clinical rating scales indicate equal improvement over this period of time for the four study groups. The Interpersonal Test Battery data were examined with a mixed-model analysis of variance. Separate analyses were performed for the variables of public behavior, conscious perception of others, and basic intentionality along the dimension of dominance-submission and affiliation-opposition. At the level of public behavior, those groups not receiving group therapy showed a substantial shift from "health" (the conscious perception of one's behavior as socially desirable) to "nonhealthy" (the perception of behavior as socially undesirable). The patients receiving psychotherapy also shifted significantly in the preconscious perceptions of others as "healthier" than they had before treatment.

87. Clark, Eleanor. Improving post-hospital care for chronically ill elderly patients. *Social Work*, 14(1): 62-67, 1969.
88. Cohen, Margery G. Alternative to institutional care of the aged. *Social Casework*, 54(8): 447-452, 1973.
89. Cohen, Margrit, and Ewalt, Patricia L. An intensive program for severely disturbed children. *Social Casework*, 56(6): 337-342, 1975.
90. Cohen, Ruth G. Outreach and advocacy in the treatment of the aged. *Social Casework*, 55(5): 271-277, 1974.
91. Cohen, Sheldon, and Hirschfeld, Eric. Use of volunteers in a school for emotionally disturbed children. *Exceptional Children*, 34(10): 757-759, 1968.
92. Cole, C.W.; Oetting, E.R.; and Miskimins, R.W. Self-concept therapy for adolescent females. *Journal of Abnormal Psychology*, 74(6), 642-645, 1969.
93. Colter, Norma C. Subsidizing the released inmate. *Crime and Delinquency*, 21(3): 282-285, 1975.
94. Combs, Ronald H., and Harper, Jerry L. Effects of labels on attitudes of educators toward handicapped children. *Excep-*

tional Children, 33(6): 399-403, Feb. 1967.

The effects of clinical labels on the attitudes of experienced and inexperienced educators toward exceptional children are examined. A sample of 80 college students represented the inexperienced professional group. The experienced professional group (80) was obtained by selection from graduate level courses. Labeled and unlabeled descriptions of mentally deficient, psychopathic, schizophrenic, and cerebral palsied children were distributed in test booklet form to the subjects. Attitudes toward the children and the labels were assessed on a 25-item rating scale which accompanied each description. The results indicate that labeling does affect the educator's perception of exceptional children, but that the effects are not consistent for different labels. For the mentally deficient, the child was seen more negatively when the description was unlabeled than when labeled ($F = 4.46$, $p < .05$). Labeled descriptions of psychopathic ($F = 7.01$, $p < .01$), schizophrenic ($F = 8.91$, $p < .005$), cerebral palsied ($F = 10.98$, $p < .001$) children are ranked more negatively than are the unlabeled versions. Experience did not seem to affect the educator's perceptions of exceptional children. (9 references)

95. Connor, Eileen M., and Muldoon, John F. Resource programming for emotionally disturbed teenagers. *Exceptional Children*, 34(4): 261-265, 1967.
96. Cortazzo, Arnold. *Activity Centers for Retarded Adults*, (DHEW Publication OS 72-93; President's Committee on Mental Retardation). Washington, D.C.: Superintendent of Documents, United States Government Printing Office, 1972.
97. Cumming, Elaine. A review article—The reports of the joint commission on mental illness and health. *Social Problems*, 9(4): 391-400, 1962.

A critical review of the first six volumes from the Joint Commission on Mental Illness and Health, with stress on policy implications, is presented. Two main criticisms are developed. One is that too little attention is paid the problems of the seriously mentally ill. The other is that given the manpower and fiscal problems analyzed in some of the reports, the final report's stress on community facilities seems rather ill founded and optimistic. New facilities may not change the tendency of all community agencies to treat the neurotic or "easy" problems and turn away the psychotic and difficult patients. The 10 main recommendations of Action for Mental Health bear little relation to the evidence accumulated in the other five volumes. In particular, the strong attack on large mental hospitals is nowhere substantiated by research. Questions of treatment and epidemiology of severe mental illness are not

explored. A quick review of the other five volumes shows that most attention, again, is given to milder forms of disturbance. The manpower volume is an excellent analysis of the most basic problem in improving mental health care. The cost of training and employing psychiatrists and their aversion for treating seriously ill patients are not adequately dealt with. In short, the findings and recommendations seem somewhat naive and fall far short of the problems addressed.

98. Curtis, Joseph E., and Miller, Dulcy B. Community sponsored recreation in an extended care facility. *The Gerontologist*, 7(3): 200–203, 1967.

99. Davids, Anthony; Laffey, John J.; and Cardin, Paul J. Intellectual and personality factors in effective child care workers. *American Journal of Orthopsychiatry*, 39(1): 68–76, 1969.

100. Davis, Ann E.; Dinitz, Simon; and Pasamanick, Benjamin. The prevention of hospitalization in schizophrenia: Five years after an experimental program. *American Journal of Orthopsychiatry*, 42(3): 375–388, 1972.

A followup study of a 1961 experiment to reduce hospitalization of schizophrenics is described. Original study patients were assigned, in random order, to one of three study groups: home-care drug group (40 percent of the sample); home-care placebo group (30 percent of the sample); hospital control group (30 percent of the sample). Patients in both home-care groups returned to their families under program supervision. The hospital control group lived in a State mental hospital. All the subjects diagnosed as schizophrenic, aged 18 to 62, showed no evidence of serious homicidal or suicidal tendencies, and had a family willing to provide supervision and cooperate in the study. Personnel for the study included a psychiatrist, a sociologist, clinical psychologist, a social worker, and five public health nurses. The program was to test the hypothesis that professional and psychiatric facilities needed for patient care could be reduced by reliance on supportive home care and a supervised drug regimen. At intake and at regular intervals during the study, all patients were monitored on psychiatric and social performance variables, namely psychiatric inventory (Lorr IMPS), social problems checklist, domestic performance scale, and social participation index. After 30 months, over 77 percent of the drug home-care patients, but only 34 percent of the placebo cases, had remained in the community. Results indicate that chronic schizophrenics could be maintained at home with drugs and supervision, at less cost than hospital care. A followup study (1964–1969) was undertaken to determine whether there were significant differences between the home-care and hospital control groups in rates

and in days of hospitalization, and whether there were significant differences between the home-care and hospital control groups in levels of personal and social performance. Ninety-two percent of the original sample of subjects were located and studied. The basic instruments used for data collection were a formal interview schedule with each patient's significant other; an informal interview with the patient; a psychiatric rating scale completed by the significant other; a formalized search of State and private hospital records to identify patients hospitalized since the end of the original study; and a formal search of clinic records over the followup period. Followup data showed no differences among the three groups for either number of hospitalizations or percentages of each group hospitalized. Followup data also showed no differences between groups on psychiatric status scores (Lorr scale) and no differences on social problems checklist. Findings showed that patients in all groups deteriorated on task performance over time.

101. Deiker, Thomas E., and Villemarette, Terry J. Liberal telephone policy in treatment and aftercare helps reduce readmissions. *Hospital and Community Psychiatry*, 24(2): 71, 79, 1973.
102. Dick, Harry R. Nature and significance of changes in the house-parent role in institutions for children. *Journal of Health and Human Behavior*, 7(3): 175-183, 1966.
103. Dick, Harry R., and Friedsam, Hiram J. Adjustment of residents of two homes for the aged. *Social Problems*, 11(3): 282-290, 1964.
104. Dinwiddie, W.F. Reciprocity of emotional transactions: A crucial issue in residential care and treatment. *Child Care Quarterly*, 3(2), Summer 1974. pp. 119-124.

    The capacity for emotional reciprocity and its place in child treatment decisions are discussed. Reciprocity is defined as the child's ability to demonstrate a giving of himself unselfishly with no thought of a return. If the child lacks this ability, institutional treatment is the only alternative. Institutional treatment makes it possible to spread the child's emotional needs among the staff, thereby preventing rejection of the child through emotional depletement of the staff. Placement decisions for children about to leave residential treatment should be based on the degree of success in the development of emotional reciprocity.
105. Dion, Karen K., and Berscheld, Ellen. Physical attractiveness and peer perception among children. *Sociometry*, 37(1): 1-12, 1974.
106. Dohrenwend, Bruce P., and Chin-Shong, Edwin. Social status

and attitudes toward psychological disorder: The problem of tolerance of deviance. *American Sociological Review*, 32(3): 417–433, 1967.

Reported are responses of 234 citizens and community leaders to six case descriptions of mental illness. Comparison with earlier studies indicate that there has been an increase in the tendency to describe as mentally ill the six fictitious descriptions. The public's judgments of who is mentally ill did not show a one-to-one correspondence with their judgments about what constituted a serious problem. Seriousness is judged not by the severity of the psychopathology evidenced by the behavior but rather by the extent to which the behavior endangers others. The leaders and the more highly educated among the cross-section respondents showed attitudes toward mental illness that appeared to be the most congruent with those of psychiatry. If the norms of the social classes themselves are used to define deviant behavior, the results contradicted the belief that more abnormal behavior is tolerated by the lower classes, even though the behavior may be disapproved by the class norms. The suggestion is made that lower status groups are predisposed to greater intolerance of the kinds of deviance that both they and higher status groups define as serious mental illness.

107. Donlon, Patrick T.; Rada, Richard T.; and Knight, Sara W. A therapeutic aftercare setting for "refractory" chronic schizophrenic patients. *American Journal of Psychiatry*, 130(6); 1973.

An experiment is reported in which two different treatment methods are used for aftercare of mental patients. Twenty-four patients who neither clinically responded to medication nor followed the recommendations of the therapist were randomly assigned to two different treatment settings. One group focused on treating the patients in a socially oriented group setting; the other focused on individual psychotherapy. All of these "refractory" patients had a marked anxiety in interpersonal relationships and a tendency to be aloof, suspicious, and noncommunicative. The diagnosis of chronic paranoid schizophrenia or chronic schizophrenia was well documented for all patients. In terms of attendance, socialization, and cost efficiency, the aftercare treatment setting which attempted to allay a patient's debilitating interpersonal anxiety with a nonthreatening milieu of acceptance and emotional support within the group setting did better than the individual therapy setting.

108. Drucker, Paula K. Short-term education in a short-term penal institution. *Crime and Delinquency*, 12(1): 58–69, 1966.

109. Dunlap, William R. Services for families of the developmen-

tally disabled. *Social Work*, 21(3): 220-223, 1976.

A survey to determine which social services are needed and which are used by developmentally disabled persons and their families is described. A total of 2,268 mentally retarded, epileptic, or cerebral palsied individuals were named by community service workers from three Alabama counties. A random sample of 600 persons was selected, stratified by incidence of each type of disability in each county. A total of 404 usable interviews was obtained. Findings showed that 275 families had received help for the disabled child; of these 275 families, 62 percent named welfare as the source of help, 17 percent said public schools, 12 percent named the crippled children's service. Twenty-nine of 292 people responding said they were in contact with associations promoting the welfare of the handicapped. Respondents named transportation, money, education, and medical service as the problems that most frequently hindered them from getting help. The lack of knowledge of available service was mentioned by only 4 percent. Seven percent of the respondents indicated there had been an effect on the marriage, and 9 percent said there had been an effect on family closeness or happiness. The finding of good family adjustment to a disabled child was contrary to previous studies.

110. Eaton, William W., Jr. Mental hospitalization as reinforcement process. *American Sociological Review*, 39(2): 252-260, 1974.

111. Edgerton, J. Wilbert, and Bentz, W. Kenneth. Attitudes and opinions of rural people about mental illness and program services. *American Journal of Public Health*, 59(3): 470-477, 1969.

112. Egan, Merritt H., and Robinson, Ora L. Home treatment of severely disturbed children and families. *American Journal of Orthopsychiatry*, 36(4): 730-735, 1966.

113. Elliott, Arthur E. A group treatment program for mentally ill offenders. *Crime and Delinquency*, 12(1): 29-37, 1966.

114. Ellsworth, Robert; Maroney, Robert; Klett, William; Gordon, Hiram; and Gunn, Robert. Milieu characteristics of successful psychiatric treatment programs. *American Journal of Orthopsychiatry*, 41(3): 427-441, 1971.

Characteristics of efficient (high turnover or release rates) and effective (low return rate or high community tenure) psychiatric units were examined. Nursing staff and patients tended to attribute negative characteristics to efficient units. Effective programs were characterized as having a motivated professional staff and active participant roles for both nursing staff and patients. Sociopsychological dimensions of 19 VA

psychiatric wards in five hospitals were studied using patient and staff Perception of Ward (POW) scales administered 3 months after the study began. The population of each unit consisted of a range of newly admitted and long-term patients of various ages and diagnoses. From the 70-item staff POW Scale, four dimensions of ward characteristics emerged from a factor analysis: motivated professional staff, nursing team as involved participants, dominant professional staff, and praise received for work. The staff POW was administered to 479 (85 percent) nursing staff. From the 111-item patient POW Scale, five dimensions of the ward program emerged from a factor analysis: inaccessible staff, involvement in ward management, satisfaction with ward, receptive-involved staff, and expectation for patient autonomy. All staff POW dimensions expect praise received for work, and all five of the patient POW dimensions significantly differentiated between the 19 units. Release and community tenure data were gathered for two populations: admission patients, admitted during the first 6 months of the study (N = 929), and resident patients (N = 1826), residing on the unit when the study began. The average admission patient on whom treatment outcome data were collected was 41.7 years old, typically married, usually schizophrenic; 40 percent had not been hospitalized in the preceding 5 years, and 49 percent had been in the community less than half of the time during this period. An admission patient was classified "released" if he left the hospital within 6 months after admission. If a released patient remained out at least 90 days, he was judged to have achieved community tenure. Of the admission patients, 781 (84 percent) were released, and of those released, 704 (90 percent) achieved community tenure. Of the resident patients, 1,171 (64 percent) were released, and 1,007 (68 percent) of these achieved community tenure. The effect of patient characteristics on outcome measures was statistically removed. The four adjusted measures of program success (admission patients' release, and community tenure; resident patients' release, and community tenure) were found to be minimally related. Results suggest that the most efficient units are those that tend not to promote patient autonomy and that are perceived negatively by staff. The most effective units are those in which nursing staff perceived the professional staff as motivated and nondominant and themselves as active participants. There were no milieu characteristics identifying overall successful programs with both high release and community tenure rates. (33 references)

115. Elpers, John R.; Miller, J. David; and Owen, Lucile. A support group for maintaining chronic patients outside the hospital.

Hospital and Community Psychiatry, 22(4): 115–118, 1971.

A program providing long-term support and needed medication in a group therapy setting in a comunity mental health center is evaluated, using the first 61 patients accepted into the program. Nearly two-thirds were diagnosed as schizophrenic. The program emphasized growth toward greater self-reliance and the formation of supportive ties with people who were not group members. The role of the therapist became that of catalyst in the development of an atmosphere of warmth, interest, dependability, and stability. The status of all 41 patients who had entered the program by June 30, 1968, was determined 1 year later. The rehospitalization rate was 22 percent for the total group of 41 and 18.5 percent for the 27 who had attended at least six consecutive meetings. Data on the work and living status of 38 of the 41 patients did not reveal statistically significant differences between patients who completed six consecutive sessions and those who did not.

116. Evje, Margaret C.; Bellander, Isabel; Giddy, Mabel; and Palmer, I. Secord. Evaluating protected hospital employment of chronic psychiatric patients. *Hospital and Community Psychiatry*, 23(7): 204–208, 1972.

117. Fabrega, Horacio, and Haka, Katerina K. Parents of mentally handicapped children. *Archives of General Psychiatry*, 16(2): 202–209, 1967.

118. Fairweather, G.; Sanders, D.H.; Cressler, K.L., and Magnard, H. *Community Life for the Mentally Ill.* Chicago: Aldine, 1969.

A description of a community work-living (lodge) program for ex-mental patients is presented. To compare the effectiveness of a lodge program with traditional community programs, all patients in the study participated in a hospital small-group (15 persons per group) treatment program. Patients were assigned to task groups, which became responsible for each member's progress through the four steps of the program. Step 1 was personal care and punctuality on assignments. Step 2 was acceptable job performance. Step 3 allowed greater freedom for use of personal money and passes, and step 4 involved the unlimited withdrawal of money and passes. Upon reaching step 4, each patient was asked whether he or she wished to volunteer for the lodge program. A volunteer was matched for age, diagnosis, and length of hospitalization with another volunteer. Each matched pair was randomly assigned to either the inhospital treatment or the lodge program. A sample of 334 individuals was obtained. Seventy-five volunteers were in the lodge program, 76 in the inhospital volunteer group, and 183 in the inhospital nonvolunteer group. Demographic data on the volunteer and nonvolunteer groups showed that lodge and nonlodge groups were not different

with respect to socioeconomic and health factors. Volunteers for the community lodge program, as compared to nonvolunteers, were hospitalized for a longer period of time, more frequently had held lower class employment positions, and held fewer jobs. One group of the small-group treatment program was picked to be the first volunteer group to move into a community work-living situation. These 15 volunteers held daily meetings to discuss problems that they would encounter in the lodge. The patients planned and set up a janitorial-gardening service that would serve as the prime source of income for the lodge members. Residents of the lodge supervised the lodge and the business; professional hospital served in an advisory-monitoring capacity. The total followup period was 40 months. Data show that median percentage of time spent in the community was greater for lodge members than for the hospital control group. Median tests at 6, 12, 18, 24, and 30 months used to compare the lodge and hospital groups (on community tenure and full-time employment) yielded chi-squares with one degree of freedom of 15.36 ($p = .001$), 12.96 ($p = .001$), 11.88 ($p = .001$), 10.95 ($p = .001$) and 4.93 ($p = .05$), respectively. Median tests comparing the employment of the lodge and control groups at 6, 12, 18, 24, and 30 months yielded chi-squares with one degree of freedom of 75.00 ($p = .001$), 30.44 ($p = .001$), 15.25 ($p = .001$), 14.02 ($p = .001$), and 7.64 ($p = .001$), respectively. Thirty-four and 40-month followup yielded chi-squares with one degree of freedom of 7.13 ($p = .01$) and 7.13 ($p = .01$), respectively. Of the 75 patients who went to the lodge, only five remained the full time (3 years). Measures of other outcome criteria including satisfaction with living conditions, leisure activity, and community living and association with friends, verbal communication, appraisal of symptom behavior, drinking behavior, activity level, social responsibility, and leisure activity show that only one, satisfaction with community living, is statistically significant (.05 level) between the lodge and control groups. It was felt that by using member supervision and work income to defray costs, the lodge program was financially feasible as a solution to the problem of chronically hospitalized mental patients.

119. Fanshel, D. *Foster Parenthood*, Minneapolis: University of Minnesota Press, 1966.

A study to determine the main characteristics and motivations for being foster parents is reported for 101 foster families. Data were collected by interviews with 101 foster mothers, interviews with 81 foster fathers, administration of the Parental Attitude Research Institute (PARI) to the foster parents, and ratings of foster parents by caseworkers. There were

28 black families and 73 white families. Of the black foster families, 79 percent cared for infants, and 55 percent of the white families cared for infants. Forty percent of the foster families had been in service with the agency for less than 3 years. Twenty-five percent of the foster couples had never had children of their own, and 40 percent of the couples had been married for at least 24 years. Foster mothers caring for infants had greater enthusiasm than those caring for older children. Eighty percent of the foster mothers reported receiving respect from other people for being a foster parent. In interviews with foster fathers, 90 percent thought that foster care was a good system for rearing children who could not live in their own homes; 70 percent felt that the role of foster parent was as important to them as it was to their wives; and 50 percent reported that being a foster parent was more satisfying than had been anticipated. Four scales were developed and used for this study. The "Benefactress of Children Scale" is a unidimensional scale used to measure the enhancement that foster mothers feel when providing care for neglected children. An "anomie scale" was used to detect nonintegration in the larger society. Foster mothers did not give anomic responses. A scale, "Capacity to Cope with Problems of Foster Children," showed whether foster parents regarded problems encountered in caring for foster children as easy or hard. "The foster parent as eccentric" scale showed the degree to which foster mothers felt other persons viewed their motives with suspicion. Reproducibility coefficiencies of these scales were satisfactory. The PARI used to assess childrearing attitudes of foster mothers asked each subject to agree or disagree strongly or mildly with each of five statements in 23 scales. The PARI scores of 77 foster mothers were compared to normative data secured from a group of 222 mothers of nursery school children and mothers of young adults. Foster mothers tended to be more authoritarian in their attitudes toward childrearing than the other group. Older foster mothers tended to be more severe and have more negative orientations toward childrearing than younger foster mothers. A factor analysis of caseworker ratings resulted in 10 factors, eight of which were interpreted. These included: Parental Adequacy—accounted for 39 percent of factor variance; Family Hierarchy Conformity—10 percent of factor variance; Tolerance for Biological Deficit—10 percent of factor variance; Motivation for Babies—9 percent of factor variance; Self-Identity and Motivation—8 percent of factor variance; Identification with Role—7 percent; Masculine Home—7 percent; Acceptance of Aggression—6 percent.

120. Fanshel, David. Status changes of children in foster care: Final results of the Columbia University longitudinal study. *Child Welfare*, 55(3): 143-171, 1976.

The final results of the analysis of status changes experienced by children in foster care over a 5-year study period are reported. Status changes included return home, placement in adoptive home, institutionalization, and remaining in foster care until adulthood. Other factors included in the study are the length of time in foster care, the number of moves to a new family, and the extent of parental visitation while in care. The subjects were 624 children who entered foster care in New York City in 1966 and were followed for 5 years. Five years after their entry into foster care, 36 percent of the subjects were still in care, 56 percent had been discharged, 5 percent were in adoptive homes, and 3 percent had transferred to institutions. Variables found to be most predictive of discharge were parental visiting, evaluation of the mother, activity of the caseworker, ethnicity, and age of the child at placement. White children available for adoption had a better chance of being adopted than minority children. Age and birth status are also strong correlates of adoptive outcome. Children transferred to State mental hospitals tended to be older and to have been neglected or abused. Almost 42 percent of the children experienced only one placement; 30 percent were placed twice; 18 percent three times; and 10 percent four times or more. Minority children had somewhat greater turnover in care. Child behavior and unwillingness of the parent to assume care were linked to fewer placements. Family problems, neglect or abuse, or abandonment showed a high number of placements. Data suggest that less active involvement of parents is associated with higher stability of placement.

121. Farina, Amerigo; Gliha, Donald; Boudreau, Louis A.; Allen, Jon G.; and Sherman, Mark. Mental illness and the impact of believing others know about it. *Journal of Abnormal Psychology*, 77(1): 155, 1971.

122. Farina, Amerigo; Holland, Charles H.; and Ring, Kenneth. Role of stigma and set in interpersonal interaction. *Journal of Abnormal Psychology*, 71(6): 412-428, 1966.

123. Farina, Amerigo; Sherman, Mark; and Allen, Jon G. Role of physical abnormalities in interpersonal perception and behavior. *Journal of Abnormal Psychology*, 73(6): 590-593, 1968.

124. Feldman, Ronald A.; Wodarski, John S.; and Flax, Norman. Antisocial children in a summer camp environment: A time-sampling study. *Community Mental Health Journal*, 11(1): 10-18, 1975.

125. Festinger, Trudy Bradley. The New York review of children in foster care. *Child Welfare*, 54(4): 211-245, 1975.

126. Figa-Talamanca, Irene. The health status and the health care problems of the aged in an Italian community. *International Journal of Aging and Human Development*, 7(1): 39-48, 1976.

127. Fine, Marvin J. Attitudes of regular and special class teachers toward the educable mentally retarded. *Exceptional Children*, 33(6): 429-430, Feb. 1967.

128. Fisch, Mayer; Goldfarb, Alvin; Shahinian, Siroon; and Turner, Helen. Chronic brain syndrome in the community aged. *Archives of General Psychiatry*, 18(6): 739-745, 1968.

129. Fisher, Thais; Nackman, Nathan S.; and Vyas, Ashutosh. Aftercare services in a family agency. *Social Casework*, 54(3): 131-141, 1973.

A family service agency program providing aftercare services to discharged mental hospital patients and their families is described. The program consisted of four stages. During the first, caseworkers helped clients look for new housing, apply for public assistance, and find community psychiatric resources. At this stage clients and their families were referred to separate groups in the project dealing with the patient's community readjustment. The second stage involved the patient in recreation programs, luncheon clubs, a newsletter, and group discussions concerning the everyday problems of living. During this stage the client, with help from the staff, was expected to enter a training program or employment and to take on additional responsibilities at home. The third stage encouraged the patient to begin to be independent of the project. Clients planned recreational programs and helped clients in earlier stages through group therapy. The fourth stage marked the patients' full independence of the project and participation in the community. Throughout the project, individual interviews, joint interviews with spouses, family therapy, group therapy, recreational therapy, and group activities were utilized to assist in the resocialization of the patient and his family. Of the 113 patients referred to the project in a 2-1/2-month period, only 27 percent needed to be rehospitalized. Earlier data had shown that 68 percent of the people discharged without receiving aftercare services from the hospital in this study were readmitted. In addition, over half of the clients were employed or in job training.

130. Fletcher, C. Richard. Social class variations in psychiatric referral of withdrawn and aggressive case descriptions. *Social Problems*, 16(2): 227-241, 1968.

131. Flint, Wallace and Deloach, Charlene. A parent involvement

program model for handicapped children and their parents. *Exceptional Children*, 41(8): 556-557, 1975.

132. Flomenhaft, Kalman; Kaplan, David M.; and Langsley, Donald G. Avoiding psychiatric hospitalization. *Social Work*, 14(4): 38-45, 1969.

An experimental trial of a family-crisis therapy program for families who have requested hospitalization for one of their members is described. The crisis-therapy team was composed of a psychiatrist, a social worker, and a nurse. Patients were referred to the crisis team by the psychiatric admission office of a State mental hospital which said that the patient needed hospitalization. The crisis team met with the family immediately after referral. The family was told that the patient's problem was manageable on an outpatient basis with professional help. All members of the patient's immediate family and significant others (i.e., relatives, friends, clergy, employers, physicians) were interviewed soon after referral to clarify and resolve current family problems. The crisis team made a home visit within 24 hours after initial contact. Drugs were often prescribed for the patient and on occasion to other family members. After the crisis was resolved, long-term problems were evaluated; families were often referred to other community resources for help with long-term problems. Thirty-six pilot cases were treated during the first year of the program (1964-65). Of these 36, 3 patients were admitted to the hospital during treatment. From 1965-68, a random sample of 150 cases was selected for crisis treatment from a group of patients diagnosed as requiring hospitalization. A control group of 150 cases from the same population were treated as inpatients at a State mental hospital. The average hospital stay of control patients was 26.1 days; the family crisis treatment cases were seen an average of 2.5 weeks. Outpatient treatment consisted of an average of five office visits, one home visit, and three telephone contacts. Hospitalization was avoided in all 150 experimental cases. Therapy for experimentals was terminated when the crisis was over and the patient had resumed precrisis level of functioning. Data for both groups were collected 6 and 18 months after the marathon of treatment to measure recent social adaptation. An analysis of baseline and 6-month measures for one-half the controls and one-half the experimentals showed that experimentals were doing as well as controls on two measures of functioning, and that the same number of experimentals as controls were hospitalized during the first 6 months after termination of treatment. Hospitalization for control cases was three times as long as that for experimental cases.

133. Flynn, John P. The team approach: A possible control for the single service schism: An exploratory study. *The Gerontologist*, 10(2): 119-124, 1970.

Presented is a study of the team approach in providing evaluation of level of care and foster care services for the aging. A team approach to assessment was used during the first 2 years of the 3-year Family Homes for the Aging demonstration project in Rochester, N.Y. A diagnostic team of a physician, a public health nurse, and a social worker evaluated the proper level of care for aging applicants. The social worker served as intake worker and coordinator. Independent and team recommendations for appropriate level of services were made. Before the project began, it was estimated that 60 persons would be placed in foster care during the first 2 years. Only 29 people were placed during that time. The project received 363 inquiries, with about half actually seen. Foster care was recommended for 41 percent of those seen, while other types of care were advised for 59 percent. Data support the contention that when more than one member of the team evaluates the situation, the level of care recommended becomes more definitive. As time passed, there were fewer recommendations of the agency's primary service, foster care.

134. Flynn, Tim M., and Flynn, Linda A. The effect of a part-time special education program on the adjustment of EMR students. *Exceptional Children*, 36(9): 680-681, 1970.

135. Foster, Glen G.; Yeseldyke, James E.; and Reese, James H. I wouldn't have seen it if I hadn't believed it. *Exceptional Children*, 41(7): 469-473, 1975.

136. Foster, Jack Donald; Dinitz, Simon; and Reckless, Walter C. Perceptions of stigma following public intervention for delinquent behavior. *Social Problems*, 20(2): 202-209, 1972.

The extent to which delinquent boys perceive having incurred a social liability as a consequence of their encounters with the police or juvenile court is examined. A sample of cases, consisting of 196 boys involved in activities definable as crimes under adult statutes, were gathered consecutively over a 3-month period from the police department and juvenile court of an urban community. Subjects were interviewed in their homes by a trained female adult interviewer using a combination of direct and open-ended questions concerning the boys' perceptions of their encounter with the police or juvenile court after the final disposition of their case. Chi-square analysis of these data indicates that only a small proportion of the boys interviewed felt seriously handicapped by their encounter with the police or juvenile court. The subjects did not perceive any substantial change in their interpersonal

relationships with family, friends, or teachers. Greatest social liability was perceived in those situations of an impersonal nature in which one's character tends to be inferred from public documents rather than through personal acquaintance with the person. These findings indicate that according to the perceptions of these officially acted-upon boys, the extent of perceived stigmatization and social liability that follow police or court intervention seems to be overestimated in the labeling hypothesis.

137. Friedman, Susan. The resident welcoming committee: Institutionalized elders in volunteer services to their peers. *The Gerontologist*, 15(4): 362-367, 1975.

138. Friedson, Eliot. Review essay: Health factories, the new industrial sociology. *Social Problems*, 14(4): 493-500, 1967.

Major studies of hospitals as social institutions published from 1955-1965 are reviewed. A few main themes are identified. It is argued that sociologists are ignoring the key questions about the production of health care by large hospitals. Service industries and hospitals in particular are different from private service industries on at least two counts. First, there is not open competition, and second, the patient or client does not have free choice in professionalized services. One theme from hospital studies has been depersonalization. The client or patient is powerless and helpless. A second theme is the attempt to eliminate "custodialism" from hospitals, especially mental hospitals. A number of analyses have extended this idea to the "therapeutic milieu" program which may be simply a form of utopianism. Hospitals are not, in fact, communities. The hospital depends on the professional community outside itself for many basic services. Further, medical treatment seems inevitably to require a hierarchy of expertise. In summary, analysts have paid much attention to the disadvantaged role of patient, but have not identified conditions for effective and humane treatment. To what extent is depersonalization actually necessary to rationalize effective treatment at a reasonable cost? Exactly which elements of hierarchical and technical organization are really required by the task? In short, much closer attention to the professional and his role and to the patient and his fate is required.

139. Frohreich, Lloyd E. Costing programs for exceptional children: Dimensions and indices. *Exceptional Children*, 39(7): 517-524, 1973.

140. Fudala, Janet Barker; England, Gene; and Ganoung, Laura. Utilization of parents in a speech correction program. *Exceptional Children*, 38(5): 407-412, 1972.

141. Garetz, Floyd K., and Peth, Peter R. An outreach program of medical care for aged high-rise residents. *The Gerontologist*, 14(5): 404–407, 1974.

142. Garfield, Sol L., and Kurtz, Richard. Clinical psychologists in the 1970's. *American Psychologist*, 31(1): 1–9, 1976.

143. Gazan, Harold S. The informal system: An agent of change in juvenile rehabilitation. *Crime and Delinquency*, 14(4): 340–345, 1968.

Described are three techniques to utilize the natural boy leadership of the informal anti-official system, and elements of the boy culture, for resocialization of delinquents in a youth rehabilitation camp setting. Two rehabilitation camps in Michigan, part of the State Boys Training School, were the setting. Camp staff used these techniques to narrow the gap between the formal value system of the camp and the informal system of the boys. First was the camp council, made up of six boys nominated and elected by the total boy population. The council opened a channel of communication between the boys and the administration. Second, in the big brother program, new boys were assigned to a boy who had been in the program at least 4 months. The big brother was responsible for the new boy for 1 week, during which he taught the new boy the routines and expectations of the camp. Positive change often occurred in the big brother. Third, community meetings or mass gatherings of all the boys were used to discuss problems that involved or influenced the majority of the camp. Use of the informal system through these techniques provided an opportunity for delinquent youths to take responsibility for others. The boys received reinforcement from the peer group to change attitudes and behavior and to learn new social skills. (3 references)

144. Geiser, Robert L. An experimental program of activity therapy in a child care center. *Child Welfare*, 50(5): 290–297, 1971.

145. Gibbons, Don C., and Blake, Gerald F. Evaluating the impact of juvenile diversion programs. *Crimes and Delinquency*, 22(4): 411–420, 1976.

146. Giovannoni, Jeanne, and Gurel, Lee. Socially disruptive behavior of ex-mental patients. *Archives of General Psychiatry*, 17(2): 146–153, 1967.

Disruptive behavior by ex-mental patients is described. Of 1,274 functional psychotics admitted to 12 Veterans Administration hospitals, 1,142 were released and were followed for 4 years from admission to ascertain extent of socially disruptive behavior. One hundred fifty-six patients were involved in 192 incidents of socially hazardous behavior. If the offenses are

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grouped broadly into those against persons, property, and morals, then the crimes against persons accounted for twice as much of the total incidence (27.1 percent) as did crimes against property (11.5 percent). Sexual offenses, contrary to popular belief, accounted for a small (7.8 percent) percentage of the total number of incidents. A rather crude comparison of rates for the patients and rates for the general population indicated that the offenses committed by patients did not follow the same frequency pattern as those reported for the general population. The disposition of the various offenses did not appear to be independent of the type of offense. While 59.1 percent of the crimes against property were handled entirely through penal institutions, only 32.7 percent of the crimes against persons were. Sexual offenses received the most widely disparate dispositions. Although almost all of the patients studied had a primary diagnosis of schizophrenia, of the 156 patients who were involved in at least one offense, 65.8 percent were also rated as having a concomitant problem with alcohol. Attempts to reconcile partially discrepant findings of this and other studies suggest the importance of understanding community utilization of mental hospitals as influencing empirical rates of ex-patient crime.

147. Glaser, Frederick B. Our Place: Design for a day program. *American Journal of Orthopsychiatry*, 39(5): 827–841, 1969.

The theory underlying day treatment at the Temple University Community Mental Health Center is explicated. The history and the social and intellectual origins of four ideas which are presented constitute a theory for the day hospital. The first idea is that of the day hospital. The key idea is not cost savings or a transitional facility in a treatment system, but that the patient is deeply involved in both the hospital and in normal home life. The patient can experiment with behaviors, and significant others can participate in treatment. The second idea is that of the therapeutic community, which can be traced to Greek medicine and which reappears as "moral treatment" and military mental hygiene. The day hospital always subscribes to the general democratic and humane principles of the therapeutic community, but there is a second and more specific application, that is, that the patients and staff form a small intimate and mutually responsible group for conduct of daily affairs. The day program at Our Place enabled support from the total center staff to achieve the second and more difficult level of community, but this was very difficult. The third idea is that of "multiple interlocking group therapy" which means that one-to-one therapy was completely ruled out. Our Place developed over 20 kinds of groups at one point,

including groups defined by purpose of activity, by characteristics of members, and by treatment technique. Daily community meetings, and a nonconfidentiality rule, served to integrate the diverse groups. The fourth idea is that of a nonmedical therapeutic setting. It has often been observed that physician-directed institutions tend to have peculiarly authoritarian and debilitating effects. On the other hand, the increasing prevalence of self-help and self-improvement groups under lay leadership indicates that the dangers of the traditional institution may be avoidable. In Our Place, the day-to-day program was largely in the hands of nonprofessional staff including several ex-patients. Decisions by physicians and other professionals are restricted to their special areas of competence.

148. Glasscote, Raymond M.; Gudeman, Jon E.; and Elpers, J. Richard. *Halfway Houses for the Mentally Ill*, Washington, D.C.: Joint Information Service of the American Psychiatric Association and the National Institute of Mental Health, 1971.

A study investigating the programs and operations of halfway houses for the mentally ill is reported. Halfway houses designed exclusively for alcoholics and drug abusers were not included in the study. The Joint Information Service of the American Psychiatric Association requested lists of halfway houses in each State. Eighty-seven percent responded, yielding names of 209 halfway houses. Of the 209 halfway houses, 182 responded to a mailed questionnaire. Of the 182 respondents, 128 accepted mentally ill persons with other categories. Of the 128 houses, 11 were chosen for personal visits, representing as much diversity as possible. Fewer than half of the respondents (60 of 128) limited their services to mentally ill. Sixty-eight of the 128 accepted other disability groups. Of the 128 houses accepting mentally ill, 10 began operating during the 1950s, and 69 were established from 1966 onward. Seventy-seven of the 128 accepted both men and women as residents. The capacity of the 128 ranged from 4 to 200. The average was 22. Thirty-six houses gave no stipulated age limits. Fifty-seven gave a lower limit only, and 34 set both an upper and a lower limit. The most common exclusions were alcoholism, drug addiction, and sex deviation. The average length of stay was 4 to 6 months. Seventy-seven houses operated under voluntary (private-nonprofit) auspices, and 34 operated under State government. Eighty-one houses named the Division of Vocational Rehabilitation or the Social and Rehabilitation Service as the most important source of funds. The next largest source, mentioned by 57 houses, was rent and fees for clients. The most common referral source (98) was State hospitals. Only 80

houses reported the charging of fees. Of the 80, 53 houses charged under $150 per month, and 11 charged more than $200 per month. Of the 128 houses surveyed, 24 provided only sheltered residential placement. Other services were vocational services (46), counseling (29), group therapy (19), workshops (10), community placement (8), medical services (7), and individual therapy (7). One hundred one houses reported a total of 503 full-time employees. Full-time staff were mostly houseparents, directors, clinical and kitchen staff, medical staff, social workers, vocational counselors, and student volunteers. Policy guidelines were extracted from the study. Public funds are needed to survive. Few problems result from mixing by sex or diagnosis, but teenagers and adults should be separated. Houses should be close to business districts and public transportation.

149. Glavin, John P. Follow-up behavioral research in resource rooms. *Exceptional Children*, 40(3): 211-213, 1973.

An attempt is made to ascertain if the academic and behavioral gains made by a group of emotionally disturbed children after 1 or 2 years of part-time placement in a behaviorally oriented resource room were maintained following 2 or 3 years of full-time attendance in regular classes. A group of teacher-referred children were randomly selected for part-time participation in a resource room; another group continued in regular classes. At the time of the followup, children were administered the Children's Intellectual Achievement Responsibility Questionnaire, designed to measure locus of control and the reading and arithmetic sections of the California Achievement Test. The behavior of each child was assessed by his present teacher by means of the Behavior Problem Checklist. Additional information on school attendance, teacher referrals for academic services, and teacher referrals on discipline complaints was obtained from each student's record. School counselors or principals were interviewed for information not indicated in the written records. Using analysis of variance and chi-square, the results indicate no significant differences between the experimental and control groups in academic achievement or social behavior as measured by the Behavior Problem Checklist, California Achievement Test, or the Children's Intellectual Achievement Responsibility Questionnaire. Thus, the initial gains in academic achievement and social behavior in the resource room that had been reported earlier for the experimental group were not long lasting. (5 references)

150. Glavin, John P.; Quay, Herbert C.; Annesley, Frederick R.; and Werry, John S. An experimental resource room for behav-

ior problem children. *Exceptional Children*, 38(2): 131-137, 1971.

A project (Temple Resource Room) developed as an alternative to special class placement for behavior problem children in public schools is described and evaluated. The program emphasized academic remediation with the use of response-reinforcement contingencies in a structured classroom situation. It was designed to be used during those periods of the day when the children were functioning least effectively in regular classes. A group of 27 children who had been identified by their teachers as having behavioral problems were selected to participate in the experimental program, while another 27 children were selected to remain in their regular classes and serve as a comparison group. The children were from the second through the sixth grades and came from diverse socio-economic areas and racial backgrounds. The 27 children participating in the program attended the resource room for differing periods, one or two per day, and for differing subjects, arithmetic or reading or both. Pre-test and post-test measures of academic achievement, California Achievement Test, and observations of both groups classroom behavior were taken. The experimental group made significantly greater gains in reading comprehension ($p < .02$) and arithmetic fundamentals ($p < .001$) than did the comparison group. Observations indicated that the program is effective in improving the children's behavior in the resource room, but that this improvement does not appear to generalize into the regular classroom. (14 references)

151. Goldberg, Richard T. The rehabilitation of the juvenile delinquent. *Rehabilitation Literature*, 34(3): 66-75, 1973.

152. Goldbried, Marvin R.; Adinolfi, Allen A.; and Dworkin, Earl. Effect of developmentally relevant information and severity of disturbance on the understanding and evaluation of deviant behavior. *Journal of Abnormal Psychology*, 74(4): 482-485, August 1969.

153. Golden, Nancy; Chirlin, Phillis; and Shone, Bernard. Tuesday children. *Social Casework*, 51(10): 599-605, 1970.

154. Goldsmith, Jean B., and McGall, Richard M. Development and evaluation of an interpersonal skill-training program for psychiatric inpatients. *Journal of Abnormal Psychology*, 84(1): 51-58, 1974.

An interpersonal, skill-training program for male psychiatric inpatients is described and evaluated. Thirty-six patients were randomly assigned to one of three experimental treatment conditions: interpersonal skill training (12), pseudother-

apy control (12), and assessment-only control (12). The interpersonal skill training consisted of three individually administered training sessions of 1-hour duration over a 5-day period. Training covered interpersonal tasks such as initiating and terminating conversations, dealing with rejection, and being more assertive and self-disclosing. Techniques used included behavior rehearsal, modeling, coaching, recorded response playback, and corrective feedback. The pseudo-therapy control consisted of three individual sessions of 1-hour duration over a 5-year period. Interpersonal problem situations were discussed, but no training was given in specific response alternatives. The assessment-only control group received only the pretreatment and posttreatment assessments. Prior to the start of the experiment, the subjects rated themselves on difficulty meeting and talking to people, expected future ability to handle social interactions outside the hospital, and their feelings of self-worth. In addition, the subjects were administered the Interpersonal Situation Inventory (ISI), consisting of 55 problematic interpersonal situations requiring the subjects to choose responses to the situations. The Interpersonal Behavior Role-Playing Test (IBRT), requiring the subject to role play prescribed situations, was also administered. At the completion of the experiment, the IBRT, ISI, and global self-report measure were readministered to each subject. In addition, the subjects were given a simulated real-life behavior test. Statistical analyses of the behavioral and self-report measures indicate that skill training is superior to the other two conditions in both the training and real-life contexts. Eight months following treatment, 20 percent of the skill training, 25 percent of the pseudotherapy, and 31 percent of the assessment-only groups had been readmitted to the hospital. (10 references)

155. Goodman, Gerald. An experiment with companionship therapy: College students and troubled boys—assumptions, selection and design. *American Journal of Public Health*, 57(10): 1772–1777, 1967.

156. Gottlieb, Jay, and Corman, Louise. Public attitudes toward mentally retarded children. *American Journal of Mental Deficiency*, 80: 72, 1975.

157. Gove, Walter R., and Fain, Terry. The length of psychiatric hospitalization. *Social Problems*, 22(3): 407–419, 1975.

The role played by the severity of a mental patient's psychiatric symptoms, and by his family's attitude toward him, in the length of a patient's psychiatric hospitalization is examined. Data concerning the patient's length of hospitalization, number of days previously hospitalized, psychiatric symptoms, age, sex, marital status, family attitudes, suicidal behav-

ior, and assaultive behavior were obtained from hospital records and psychiatrists' interviews for all patients (224) admitted to a State mental hospital from one county over a 16-month period. These patients were admitted to a demonstration treatment program and received somewhat better treatment than is typical for State hospital patients. Path analysis was used to analyze the determinants of the length of hospitalization. Family attitude was not an important determinant of the length of hospitalization. Findings suggested that psychiatric symptoms, marital status, and possibly previous hospitalization were determinants of the length of a patient's hospitalization.

158. Gove, Walter, and Lubach, John E. An intensive treatment program for psychiatric inpatients: A description and evaluation. *Journal of Health and Social Behavior*, 10(3): 225–236, 1969.

159. Grad, Jacqueline C. A two-year follow-up. In: Williams, Richard H., and Ozarin, Lucy D., eds., *Community Mental Health: An International Perspective*. San Francisco: Jossey, Bass, 1968. pp. 429–454.

The success of two English community care services is assessed in terms of reduction of "social cost" from mental illness. Reduction in social cost was defined as decreased burden on families and restored ability to work. One of the services showed better results than the other. The difference was attributed to better social and health service in the community. A random sample of all persons referred to two community mental health services in 1960-1961 was followed up 2 years later. Chichester admitted fewer patients to hospitals than Salisbury and was called the "community" service. Salisbury's service was hospital-based. Family problems at referral were similar, with about two-thirds in each community finding patients to be a burden. When the 329 families were interviewed 2 years later, over half had been relieved. The extra work entailed by the patients was considerable in both communities, but not significantly different. About half the men in each community, at referral, had problems related to maintaining employment. In reduction of burden to family and in problems with work as well, Salisbury had a better record at the end of 2 years. The better record of the hospital service in relieving family burden could not be accounted for simply by its greater use of the hospital. Amounts of social and community services were greater in Salisbury, and differences in outcome were attributed to these ancillary services.

160. Graziano, Anthony M. Clinical innovation and the mental health power structure: A social case history. *American Psychologist*, 24(1): 10–18, 1969.

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The progress of innovative ideas to the level of action is traced by examining a case history in which a group of parents of autistic children, having new ideas concerning their treatment, encountered the resistance of the local mental health power structure. The parents fought for the implementation of a program based on psychological learning concepts as an alternative to traditional psychoanalytic treatment. The successes and failures of this attempt are examined over an 11-year period in terms of the attempts made at financing the program and the relationship of the advocates of the program with the mental health establishment in the area. On the basis of the case study, it is suggested mental health professions in this country have developed viable community-based professional and lay power structures which are composed of mutually benefiting bureaucracies in which scientific and humanitarian ideals are incompatible with and have been supplanted by the professionals' primary loyalty to the professional power structure. It is also suggested that by focusing on self-preservation, these power structures maintain a dogmatically restrictive view of human behavior and the roles of a professional within that structure and thereby prevent the development of true innovations. (5 references)

161. Greenberg, David F. A voucher system for correction. *Crime and Delinquency*, 19(2): 212-217, 1973.

162. Greenley, James R. The psychiatric patient's family and length of hospitalization. *Journal of Health and Social Behavior*, 13(1): 25-37, 1972.

Evidence is presented to show that attitudes held by the families of psychiatric patients affect their length of hospitalization. Information came from structured interviews with, and informal observations of, 125 consecutive psychiatric patients admitted to a State mental hospital from a medium-sized New England city. Data were also collected from their psychiatrists and their families on whether families wished their relatives to remain hospitalized, the patient's psychiatric symptoms, his dangerousness to himself or others, and professional judgments of his condition and need. Using the gamma statistic, the results indicate that family wishes concerning release were significantly related to the length of hospitalization ($p < .001$). This relationship remained significant regardless of whether the patient is seen professionally as dangerous, highly psychiatrically impaired, or in need of further hospitalization.

163. Greiff, Shirley A., and McDonald, Robert D. Roles of staff in a psychogeriatric day care center. *The Gerontologist*, 13(1): 39-44, 1975.

164. Grimberg, Moises, and Franzen, Lincoln. A program of simulated community living. *Hospital and Community Psychiatry*, 21(6): 192-193, 1970.

165. Guerin, Gilbert R., and Szatlocky, Kathleen. Integration programs for the mildly retarded. *Exceptional Children*, 41(3): 173-179, 1974.

Methods for integration of mildly retarded students in public elementary schools of eight California school districts are reported. Four program models—partial integration, combination class, learning resource center, and learning disability group—are identified. Interviews were conducted with 17 administrators and 31 teachers; regular classroom observations were made of 27 retarded pupils and 54 randomly selected, nonretarded pupils, and an index of integration was developed and applied to each program. Analyses of these data indicate that (1) partial integration was employed most frequently, offered the least amount of integration for the retarded student, and enjoyed the least amount of teacher support; (2) combination classes, learning resource centers, and learning disability groups offered the retarded student the maximum amount of integration and received the strongest teacher support; (3) the attitudes of administrators and the majority of teachers were positive toward integrated programs; and (4) the behavior of retarded students was essentially similar to that of regular students. (7 references)

166. Gullotta, Thomas P. Teacher attitudes toward the moderately disturbed child. *Exceptional Children*, 41(1): 49-50. Sept. 1974.

167. Gunn, Robert L.; Gearman, Henry E.; Groth, Clarence; Wagnn, Mervyn K.; and Harrelson, Wayne. Factors influencing release decisions. *Hospital and Community Psychiatry*, 21(9): 290-293, 1970.

Eight teams in a mental hospital, each consisting of a psychiatrist, a psychologist, a social worker, a nurse, and a nursing attendant, are studied to identify factors influencing release decisions. A 40-item rating schedule was administered to each team member when a patient was being discharged. Importance of social factors, psychological factors, administrative factors, and environmental factors were rated. The schedule was completed for 10 patients by each of the eight teams, a total of 80 releases. The raters as a group placed the least importance on administrative factors. Social and environmental factors were rated the most important. Significant differences were found between teams, disciplines, and the interaction of discipline and team on all factors. The variance between teams was the most pronounced on psychological factors and the

least on administrative factors. The greatest differences between disciplines were found on environmental factors. However, when members of various disciplines work together as a team, they tend to develop a group orientation or value system, which may differ greatly from that of another team in the same hospital.

168. Gustafson, Elizabeth. Day care for the elderly. *The Gerontologist*, 14(1): 46-49, 1974.

169. Guthrie, Victor L., and Gasdick, Jane M. Rehabilitation through improvement of social skills. *Social Casework*, 54(1): 42-44, 1973.

A rehabilitation program called "Social Improvement Program" and designed to correct deficiencies in the conduct of institutionalized persons by giving them practice, while in the hospital, in the day-to-day skills needed to live outside an institutional setting is described. The program consisted of three stages. Patients without psychotic symptoms and destructive behavior spent 1 hour a day in learning menu planning, food buying, budgeting, housekeeping, washing clothes, grooming, personal hygiene, and interpersonal social skills. After mastery of these basic skills, the patient was admitted to the day program to practice the skills learned in the first stage in an apartment setting on the hospital grounds. During the third stage, the patients moved into the apartment and were without staff guidance during night hours. Also patients had industrial therapy assignments or worked all day in sheltered workshops. Finally patients visited a group home for 1 to 6 days so that their skills could be further refined. Staff efforts in this program range from group therapy and individual counseling to advising on money management. In the first 40 months of the program, 87 of the 151 patients enrolled in the program successfully completed it and were discharged with 14 of this group later returning to the hospital.

170. Guttmann, David, and Miller, Phyllis R. Perspective on the provision of social services in senior citizen centers. *The Gerontologist*, 12(4): 403-406, 1972.

A survey is reported on the issue of whether senior citizens centers have significant roles as social service agencies. The study is based on all senior centers in the United States with a membership of 1,000 or more. Four major social services were considered relevant for direct provision by senior centers: health services, financial services, housing services, and employment services. A questionnaire with 43 questions was sent to the directors of 125 centers, with a total listed membership of 328,480. Of the responding centers, 70 were selected as a sample, having a total membership of over 150,000. The ques-

tionnaire asked about services offered by the centers and about their assessment of future needs. About 50 percent of the centers did not provide housing services; 60 percent did not provide financial services; 37 percent did not provide health services; and 38 percent did not provide employment services. For many centers, "provision of services" was actually referred to other community agencies. The centers seemed to favor indirect information and referral services over direct services. Social services offered by senior centers were judged inadequate. There is serious doubt about the role of these centers as multiservice agencies for the elderly. (17 references)

171. Hacker, Sally L., and Gaetz, Charles M. Evaluating the actions of a mental health team. *The Gerontologist*, 12(2): 155–162, 1972.

Reported is an experiment in which an interdisciplinary team made health plans with elderly mental patients. Team members from five disciplines (psychology, psychiatry, social work, nursing, and general medicine) devised care plans for 100 elderly patients and then coordinated health care for these patients for 1 year. The 100 subjects had been consecutively admitted to a county psychiatric screening ward. A control group consisted of 110 similar patients admitted 1-1/2 years earlier who had received traditional service without team-supervised health planning and followup. The experimental group was tested and interviewed 6 months and again 12 months after first entering the county screening ward. The control group was tested 12 months after entering the ward. This study compares the experimental and control groups in attitudes toward the intake process and in subjects' evaluations of treatment. At the 12-month point, the number responding was 42 experimental and 39 control. About one-fifth of the patients had died, and others could not or would not respond. T-tests show no significant differences in cognitive impairment, functional capacity, physical status, or income. At the time of admission to the screening ward, over one-half of each group had no idea what to expect; another 20 percent expected to be treated and released. The team approach does not seem to alleviate the confusion over admission or the overall negative effect the ward has on most patients. The hypothesis was not supported that under the team approach the patient would obtain more information, understand it, or recall it better. Of the controls, four-fifths were committed to a State hospital. Of the experimentals, only one-fourth were committed. Other options were nursing homes, local mental and general hospitals for short-term stays, and supervised home care. In the experimental group, about half of the patients and families

reported they participated in planning and also received explanations of decisions. Almost none of the controls reported either. More team patients said the solution chosen for their problem was a good one and that the approach taken was effective. Family members tended to give positive evaluations of the team's effect on the patient, though few fully understood the team's function. The team method was judged as more effective and more humane than traditional care despite lack of support for the original hypothesis. (9 references)

172. Hackler, James C. Boys, blisters, and behavior: The impact of a work program in an urban central area. *Journal of Research in Crime and Delinquency*, 3(2): 155–164, 1966.
173. Halpern, Werner I. The schooling of autistic children: Preliminary findings. *American Journal of Orthopsychiatry*, 40(4): 665–671, 1970.
174. Hamilton, Marian W. The hospital and the household. In: Williams, Richard H., and Ozarin, Lucy D., eds. *Community Mental Health: An International Perspective*. San Francisco: Jossey-Bass, 1968. pp. 416–428.

    The burden imposed on families caring for a mentally ill member was investigated. Interviews with families of 273 patients, seen 4 years earlier in two general hospital clinics in England, indicated many objective signs of burden but revealed that only one family in five experienced a heavy burden. The sample was stratified to overrepresent aged, schizophrenic, epileptic, and organic conditions; the specified conditions made up half the sample. Two kinds of "objective burden" were defined. The first was effects on income, health, children, and family life, and the second was incidence of abnormal behavior such as dangerous, restless, or talkative behavior. Families were also asked about "subjective burden" and about supports from community services. Adverse effects on the family and abnormal behavior, taken one by one, were each experienced by a small proportion of the families. One-twentieth to one-fifth of the families experienced each of the objective burdens. Taken together, about half the families were free of any objective burden. Duration of illness was highly associated with "burden." When subjective burden was examined, three-fourths of the families with objective burden experienced subjective burden, but only one-fifth rated it as severe. Older patients were significantly more often considered a burden. Use of community services was low. Conjugal families experienced greater objective burden but complained less.
175. Harris, Raymond. Geriatric cardiac rehabilitation. *The Gerontologist*, 7(2): 82, 1967.

176. Heap, Robert F.; Boblitt, William E.; Moore, Charles H.; and Hord, James E. Behavior-milieu therapy with chronic neuropsychiatric patients. *Journal of Abnormal Psychology*, 76(3): 349–354, 1970.

177. Heckel, R.U.; Perry, C.; and Reeves, P.G. *The Discharged Mental Patients: A 5-year Statistical Survey.* Columbia: University of South Carolina Press, 1973.

A study of admissions and discharges in a South Carolina State hospital is reported. Information was gathered from 426 males and 461 females admitted to the hospital from the eight most populous counties of South Carolina and with regular admission status. Six-hundred thirty-seven had no previous hospitalization. Data collectors gathered information from patients or, when necessary, from relatives. Data included occupation and income, religious participation, community participation, previous hospitalization or treatment for mental disorder, kinship composition of household, mortality in patient's parental family, mortality in patient's conjugal family, residence, education, police history and marital history. Diagnoses were as follows: acute brain disorders 5.5 percent, chronic brain disorders 6.5 percent, psychotic disorders 37.5 percent, psychoneurotic disorders 22.5 percent, personality disorders 8.5 percent, mental deficiencies 5.5 percent, alcoholism 1.0 percent. Data show that personal characteristics, work, and mental history do not reveal gross deviation from a normal population. Behavioral breakdown occurred in social behaviors concerned with dealing effectively with others, especially family. During hospitalization, research staff questioned 365 persons of the total 887 regarding attitudes toward hospitalization, relationships within the family, and family history in detail. There was no one outstanding or primary deficit area of functioning. Followup measurements were taken 3–4 months after initial hospitalization, and then annually for 3 years. There was increased social sufficiency and competency. By the end of the third year, 48 patients (15 males and 33 females) remained in the hospital.

178. Henley, Barbara, and Davis, Milton S. Satisfaction and dissatisfaction: A study of the chronically-ill aged patient. *Journal of Health and Social Behavior*, 8(1): 65–75, 1967.

The relationship between the general satisfaction of elderly patients, their characteristics, and factors in their current environment is investigated. Information concerning changes caused by illnesses, difficulties in ambulation, diet, sleeping, medications, living arrangements, financial adjustment, vocational experiences, adjustment to illness, family relationships, and satisfaction in general was gathered in separately con-

ceived structured nursing and social work interviews with a random sample of 167 persons, age 60 and over, attending a clinic of a large urban teaching hospital. Based on a contingency and chi-square analysis of the patients' self-evaluations, 71 percent of the group saw themselves as satisfied and 29 percent as dissatisfied. The patients were likely to be generally satisfied ($p < .05$) with their way of life if they had generally pleasant relationships with members of their household or did not mind living alone, if they felt that their health was good compared to that of others the same age, if they felt they could count on some help at home in case of acute illness, and if they felt comfortable financially.

179. Herr, David. Camp counseling with emotionally disturbed adolescents. *Exceptional Children*, 41(5): 331-332, 1975.

180. Herz, Marvin I.; Spitzer, Robert L.; Gibbon, Mirian; Greenspan, Kenneth; and Reibel, Stephen. Individual versus group aftercare treatment. *American Journal of Psychiatry*, 131(7), 1975.

Reported is an experiment in which 144 were randomly assigned to either group therapy (N = 76) or individual (N = 68) therapy. Treatment in both groups was supportive, reality-oriented psychotherapy with little if any emphasis on insight. Only small improvements were achieved by patients in either treatment mode. Patients were maintained in the community, but there was no significant improvement in their level of psychopathology and role functioning. The therapy was conducted by first-year psychiatric residents. Each therapist was assigned approximately 12 patients who were to be seen only during a 1½-hour weekly evening clinic. Thirty-six patients were never seen. As a group these patients could be described as chronically ill and socially impaired. There were no significant differences between the two treatment modalities on any of several psychopathology measures. Results of an attitude questionnaire given to the therapists showed that 8 of 12 would have preferred to treat their patients with individual therapy when the program started. By the 12th month, 4 of the 8 who initially preferred individual therapy shifted their preference to group therapy, while none of those who initially preferred group therapy changed.

181. Hewett, Frank M. Educational engineering with emotionally disburbed children. *Exceptional Children*, 33(7): 459-467, 1967.

182. Hewett, Frank M.; Mayhew, Donald; and Rabb, Ethel. An experimental reading program for neurologically impaired, mentally retarded and severely emotionally disturbed children. *American Journal of Orthopsychiatry*, 37(1): 35-48, 1967.

183. Hewett, Frank M.; Taylor, Frank D.; and Artuso, Alfred A.

The Santa Monica project: Evaluation of an engineered classroom design with emotionally disturbed children. *Exceptional Children*, 35(7): 523–529, 1969.

The effectiveness of the engineered classroom design in maintaining student attention to tasks and in improving the academic achievement level of children with learning and behavior problems is assessed. The classroom for the program was divided into three centers: the mastery and achievement center with students' desks and two study booths where academic assignments are given; the exploratory-social center where science, art, and communication activities take place; and the attention-response-order center which provides simple direction following tasks. Each class day is divided into 2 hours of reading, written language, and arithmetic, 1 hour of exploratory activities, and 1 hour of physical education. A group of 54 children with learning and behavior problems, aged 8 to 12, were assigned to six project classrooms in which one class rigidly adhered to the engineered classroom design; another followed any approach the teacher chose to follow; two others began the year with the engineered design and switched in the middle of the year to any approach the teacher chose to follow; and two others began the year using any approach the teacher chose to follow and switched in the middle of the year to the engineered design. All students were administered the California Achievement Test at an initial screening, once at midyear, and once at the close of the project. Task attention of students was significantly facilitated by the experimental condition when that condition was introduced to emotionally disturbed children following placement in a control condition class. Task attention was also facilitated by removal of the experimental condition from classes which had become accustomed to it over a one-semester period. Reading achievement was not significantly affected by either the experimental or control condition, but gains in arithmetic fundamentals were significantly correlated with the experimental condition. (11 references)

184. Hicks, John J., and Wieder, Daniel. The effects of intergeneration group counseling on clients and parents in a vocational rehabilitation agency. *Rehabilitation Literature*, 34(12): 358–363, 1973.

185. Hobbs, Nicholas. Helping disturbed children: Psychological and ecological strategies. *American Psychologist*, 21(12): 1105–1115, 1966.

A project (Re-Ed) is described for the reeducation of emotionally disturbed children, developed as a new way to meet a social need for which current institutional arrangements are

inadequate. Children who were normal or superior in intelligence but were in serious trouble at school, who did not need continuing medical care, and who could be managed in small groups in an open setting were selected as participants in a residential school program. The school strove to be homelike and provided individualized education and organized play activities. Parents were actively involved in discussion groups and organized activities and performed a variety of tasks that were aimed at reestablishing the child as quickly as possible in the community. The program operated weekdays with children going home for the weekend in order to avoid the estrangement that can come from prolonged separation and to give the child and his family an opportunity to learn new and more effective ways of living together. In terms of cost per child served, the cost of a Re-Ed program is equivalent to or less than the cost of custodial care. Observations of interpersonal relations and ratings of observers at the time of admission and 6 months after discharge indicated that this cost may be worthwhile. Observers reported decreases in symptoms, such as bedwetting and school fears, and increases in social maturity and school adjustment.

186. Hoenig, J., and Hamilton, J. *The Desegregation of the Mentally Ill.* London: Routledge and Kegan Paul, 1969.

A 4-year study is reported, concerning factors correlated with mental hospital admission. This study was conducted in England in two psychiatric units in general hospitals with a declared policy of avoiding long-term mental hospitalization. The purpose of the study was to follow a cohort of psychiatric admissions, to discover their subsequent experience with treatment, especially in patient treatment. A representative sample was drawn from a total of 959 patients admitted to the two units over a 12-month period. The total sample was 273 patients. A psychiatric social worker contacted and interviewed all but 35 of the 273 patients approximately 4 years after initial hospitalization. Of the sample, 4 percent had been ill for more than 2 years before admission to the unit; and another 27.5 percent had been ill for 7 months to 2 years before admission to the unit. Eighteen percent had received psychiatric treatment before admission to the unit. Seventy-five percent of the patients were referred to the psychiatric unit by general practitioners. Eighty-one percent of the total sample were not admitted, during the 4-year study period, to a mental hospital; 11 percent entered for short stays of not more than 3 months for all 4 years; 2 percent entered and stayed less than 1 year; and 6 percent entered and stayed longer than 1 year. Thirty-four percent of the 273 patients were never admitted as in-

patients in the psychiatric units; 34 percent were inpatients for less than 1 month; 21 percent were unit inpatients for less than 3 months; and 11 percent were unit inpatients more than 3 months. Those diagnosed as schizophrenic or epileptic were overrepresented among the longer stay unit inpatient group. Those over 60 tended to use inpatient services more often. Mental ill health through the 4-year period was assessed. Forty-eight percent of the 273 were mentally ill for less than 6 months, 17 percent for from 7 to 24 months, and 35 percent for more than 2 years. Nineteen percent were physically ill for more than 2 years of the followup time, 3 percent for the entire 4 years, and 6 percent for from 7 to 24 months. Seventeen percent of the patients died from natural causes during the 4 year followup period, and 1 percent died of suicide. Personality disorders, abnormal psychogenic reactions, and affective psychoses were more numerous among the short-term psychiatric mobility cases. Twenty-six percent of schizophrenics were mentally ill for less than 1 month. Of the 113 patients of working age, 39 percent had no unemployment for the followup period. Thirty-seven percent of the patients were unemployed more than 50 percent of the followup period, and 25 percent of the patients were unemployed for 75 percent of the followup time. Degree of social isolation was measured in terms of the patient's degree of confinement to his/her home. Twenty-five and one-half percent were totally confined to the house, and 27.5 percent were partially confined. Data showed that 90 percent of the schizophrenic patients spent up to 2 years of the followup time in the communmity; 25 percent were free of symptoms for as long as 3 years, and 46.5 percent were ill for 2 years or more. Of the schizophrenics, over 30 percent worked for 75 percent of the followup period, and 30 percent were unemployed throughout the 4 years. Nineteen percent of the over-60 age group were never inpatients during the followup, and 6 percent had a total inpatient stay of more than 1 year.

187. Hogarty, Gerald E. The plight of schizophrenics in modern treatment programs. *Hospital and Community Psychiatry*, 22(7): 197-203, 1971.

An essay is presented, criticizing community mental health programs for failure to help schizophrenic patients. The discrepancy between existing treatment services and needs of schizophrenic patients is approached in terms of primary, secondary, and tertiary prevention. Applied to schizophrenic patients, primary prevention involves a spectrum of activities in educational and community organizations to promote health or encourage high-risk groups to use the formal and

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informal treatment resources that exist. When primary prevention fails and the schizophrenic patient requires care, the point at which he enters the treatment network is more often a matter of chance than of choice. Brief intensive-care programs are by far the most numerous and most rapidly expanding agents of secondary prevention. For the vast number of schizophrenics whose deficiencies in social competence and motivation are paralleled by severe family disorganization and lack of community resources, brief intensive crisis intervention with chemotherapy can probably not bring about lasting symptomatic remission, personal rehabilitation, or social restoration. Partial hospitalization has been heralded for reducing inpatient care; but the limits of treating schizophrenics in day hospitals remain largely unknown. Those accepted for treatment are those who survive a selection process determined by the referring process and the program personnel. Residential placement of former hospital patients frequently is the only portal of entry to the community. Housing and comprehensive programs of social and vocational rehabilitation are needed for chronic patients who do not need to stay hospitalized. As a deterrent to indiscriminate and unsuccessful community placement of chronic patients, we need bold, imaginative approaches to rehabilitative aftercare. There is a pressing need for more aggressive and innovative methods to reach patients who for one reason or another do not enter or remain in aftercare.

188. Hogarty, Gerald E.; Goldberg, Solomon C.; et al. Drug and sociotherapy in the aftercare of schizophrenic patients. *Archives of General Psychiatry*, 28(1): 54-63, 1973.

An experiment is reported in which 374 discharged schizophrenic patients from three State hospitals were randomly assigned to major role therapy (MRT) or to usual treatment. MRT is a sociotherapy consisting of intensive individual social casework and vocational rehabilitation counseling. Patients were also randomly assigned to drug therapy or placebo treatment. Study patients were evaluated on psychiatric history, psychopathology, social behavior, and adjustment as reported by the treating psychiatrist, social worker, vocational rehabilitation counselor, research assistant, family members, and patient. Patients were evaluated at discharge from the hospital and again at intake into the study program at 1, 2, 6, 12, 18, 24, and 36 months following intake. The results indicated that the difference between MRT and non-MRT over the entire controlled phase was not significant. However, the MRT group were rehospitalized less often after the sixth month than the non-MRT group ($p < .02$). The effects of MRT and drugs are

additive as opposed to interactive. The superiority of MRT over non-MRT, particularly in the latter months, is not a function of the specific clinic in which it was obtained.

189. Hogarty, Gerard E.; Goldberg, Solomon; and Schooler, Nina R. Drug and sociotherapy in the aftercare at schizophrenic patients: III. Adjustment of nonrelapsed patients. *Archives of General Psychiatry*, 31(5): 609–618, 1974.

190. Hogarty, Gerard E.; Goldberg, Solomon; Schooler, Nina R.; and Ulrich, Richard F. Drug and sociotherapy in the aftercare of schizophrenic patients: II. Two-year relapse rates. *Archives of General Psychiatry*, 31(5): 603–608, 1974.

The effects of maintenance phenothiazine treatment and major role therapy (MRT) are examined in forestalling the relapse of 374 schizophrenic patients recently discharged from three Maryland State hospitals. Relapse was defined as clinical deterioration of such magnitude that rehospitalization was imminent. About 75 percent of relapsed patients were actually rehospitalized. Patients stratified by sex were randomly assigned to all possible combinations of drug-placebo and MRT-no MRT. The MRT was administered by social workers with master's degrees and an average of nearly 7 years' experience. The MRT was viewed as a psychosocial, problem-solving method designed to respond to the interpersonal, personal, social, and rehabilitative needs of study patients and their families. A factorial analysis of variance (drug by MRT by sex by race by hospital) was computed with regard to the length of time a patient survived in the community during the entire 24 month study, and separately for the 1st year. Chlorpromazine is significantly more effective than placebo in forestalling a patient's relapse ($p < .001$). The average time that drug-treated patients survived in the community during the 2 years of study was 17.4 months, but only 10.3 months for placebo-treated patients. Although the drug was more effective than placebo for both men and women, the size of the drug/placebo difference was significantly greater for women than for men. There was no significant effect of MRT itself in forestalling relapse. Among patients who survived at least 6 months, 44.3 percent of those receiving MRT and 57.8 percent of those in the non-MRT group relapsed between 7 and 24 months ($p = .05$). Although there was a main effect for sex, with female patients surviving longer than male patients, this difference occurred only among drug-treated patients.

191. Holden, Constance. Community mental health center: Storefront therapy and more. Science, 174(4014): 1219–1221, 1971.

192. Holden, Constance. Mental health: Establishment balks at innovative psychiatrist. *Science*, 181(4100): 639–640, 1973.

193. Holland, Thomas P. Changing social policies on mental retardation. *Social Service Review*, 46(1): 251–262. 1972.

Conflict theories of social change are applied to the structure of social provisions for the mentally retarded. As a premise for the analysis, it is noted that large expenditures and much public attention have led to only minor changes in social provisions. Certain theories of social change are summarized. Mentally retarded people have been devalued and excluded from social institutions, this extrusion rationalized by emphasis on their incapacities. The medical profession among others has used these public attitudes to reinforce their own status and increase their control of resources. The pressure groups for the retarded, notably National Association for Retarded Children (NARC), 1950 to present, encountered strong and effective opposition from the American Medical Association (AMA) before Congress. The AMA was successful in capturing half or more of the new resources for established medical research centers, hospital programs, medical education, and the like. In many cases the socially high-status citizen leaders of NARC have joined AMA interests to pursue biomedical research and specialized programs rather than upgrade long-term care. Needs of the large group of borderline retarded, whose deficits are combined with social disadvantages, require continuing and more energetic advocacy.

194. Holt, Norman. Temporary prison release: California's prerelease furlough program. *Crime and Delinquency*, 17(4): 414–430, 1971.

195. Holzman, Seymour, and Sabel, Norman E. Improving the morale of the patients and the staff in a geriatric institution by a supervised visiting program. *The Gerontologist*, 8(1): 29–33, 1968.

196. Iano, Richard P.; Ayers, Dorothy; Heller, Howard B.; McGettigan, James F.; and Walker, Yalaida S. Sociometric status of retarded children in an integrative program. *Exceptional Children*, 40(4): 267–271, 1974.

197. Ingram, Gilbert L.; Gerard, Roy E.; Quay, Herbert C.; and Levinson, Robert B. An experimental program for the psychopathic delinquent: Looking into the "correctional wastebasket." *Journal of Research in Crime and Delinquency*, 7(1): 24–30, 1970.

A demonstration project conducted at the National Training School for Boys compared a nonverbal, action-oriented approach to treating psychopathic delinquents to the regular counseling approach. A program emphasizing change, action, and novelty was developed, including organized recreation that varied nightly, slot car racing for which the youths built

their own model cars, athletic competition with staff, an innovative religious program, weight lifting, special tournaments and excursions, and psychodrama. Staff tried to eliminate any possibility of the youths anticipating and manipulating the programs. Points equal to pennies were awarded for positive behavior and for winning in competition. Instead of isolating boys for rule violations, they were put in a "time out" room for 3 minutes. The 20 most recent "psychopathic" admissions were chosen as the study group. Two control groups, composed of all psychopaths admitted after the project began (21) and previous commitments who would have qualified for the project (20), were formed. These three groups were similar in terms of race, IQ, and type of commitment. The project's objectives were to increase the amount of in-program time for the hard-core delinquent, to lower the degree of aggressive behavior, and to better their total level of adjustment. These objectives were measured by the average number of days in isolation, average number of assaultive offenses, and type of release from the institution. Project youth spent significantly fewer days in isolation than the controls. There was not a significant difference in the number of assaultive offenses, though there was a difference in the predicted direction. The project group showed significantly better adjustment, as measured by type of release. Separating psychopaths from the general population for differential treatment proved to be an effective procedure. (2 references)

198. Jacobs, John F., and Pierce, Marnell L. The social position of retardates with brain damage associated characteristics. *Exceptional Children*, 34(9): 677-681, 1968.

199. Jansen, Elly. The role of the halfway house in community mental health programs in the United Kingdom and America. *American Journal of Psychiatry*, 126(10): 1498-1504, 1970.

Various approaches to halfway house operations are discussed, emphasizing the organizational philosophy that developed in England as a result of an experimental program. Observations indicated that most halfway houses in England and America underestimated the residents' capacity to take responsibility. Thus, there were strong elements of patronage by staff. This emphasis was believed to be changing to one with higher expectations of and respect for patients. Management of houses tended to emphasize either authoritarianism, resulting in an impersonal, repressive setting or self-government and the contribution of each person to the recovery of the community members. Many halfway house programs exhibited strong antiprofessionalism and used a moral therapy approach which provided jobs for residents to counteract their

problems. A halfway house experiment was conducted in Richmond, London, in 1959. Goals established by the residents were to provide a realistic setting in which members could be helped and could help one another to understand themselves and to relearn social skills. The program's task was to reintegrate members into society and to encourage their independence. It became obvious that if halfway houses were to fulfill a major role, they would need to join forces, learn from one another, and undertake certain tasks together. Therefore, the Richmond Fellowship was formed with the task of purchasing properties, raising funds, negotiating financial terms with State and other authorities jointly for all houses, recruiting and training staff, formulating standards, providing staff and residents with the most appropriate placement, and conducting research. The organizational approach proved effective. At the time this article was written, 16 houses existed in England, staff training had developed into a full-scale college with inservice and full-time courses in group work and human relations, and the Richmond Fellowship of America was incorporated in 1968. It is argued that if halfway houses grow independently of each other, the movement will be condemned to insignificance, amateurism, and instability. (7 references)

200. Jenkins, Joseph R.; Mayhall, William F.; Peschka, Corinne M.; and Jenkins, Linda M. Comparing small group and tutorial instruction in resource rooms. *Exceptional Children*, 40(4): 245-250, 1974.

201. Jensen, Gordon D., and Womack, Mariette G. Operant conditioning techniques applied in the treatment of an autistic child. *American Journal of Orthopsychiatry*, 37(1): 30-34, 1967.

202. Jesness, Carl F. The Preston typology study: An experiment with differential treatment in an institution. *Journal of Research in Crime and Delinquency*, 8(1): 38-52, 1971.

The feasibility and effectiveness of the Interpersonal Maturity Level (I-level) Classification system are investigated at the California Youth Authority's Preston School of Industry. The "I-level" ratings were determined through an interview, an inventory, and a sentence-completion test. The study sample was comprised of boys who arrived at Preston during a 13-month period. All subjects not preselected for special programs were randomly assigned to the experimental or the control group. Experimental subjects were placed in one of six living units where unique treatment programs were developed according to their I-level subtype. Controls were assigned to one of five living units according to normal procedure. After all attritions, 655 experimentals and 518 controls

remained. Treaters were matched to treated according to the treaters' personalities, interests, and working styles. Estimates of unit climate were obtained from a questionnaire given to the boys, ratings by outside experiments, and the Moos Social Climate Scale. The I-level system tended to decrease management problems, as reflected in fewer serious incident reports and a significant reduction in the use of confinement in experimental units. Pre- and post-program psychological and behavioral measures showed significantly greater gains by the experimental subjects. Followup parole data showed performance of experimental and control groups to be the same. A chi-square analysis failed to show statistically significant differences between experimentals and controls for any of the subtypes. (13 references)

203. Jesness, Carl F. The impact of behavior modification and transactional analysis on institution social climate. *Journal of Research in Crime and Delinquency*, 12(2): 79-91, 1975.

Data are presented showing the impact of two experimental programs on the social climates at two California institutions for delinquent boys. The effectiveness of a Behavior Modification Program at the Karl Holton Institution and a Transactional Analysis Program at the O.H. Close Institution were compared using the Correctional Institutions' Environment Scale (CIES) to measure dimensions of relationship, treatment program, system maintenance, and aggression in the institution's social environment. Subjects included all 15- to 17-year-old boys assigned to the California Youth Authority's (CYA) Northern Youth Center from August 1969 to March 1971. Subjects were randomly assigned to Close or Holton, which appeared to have almost identical programs at the time of the pre-test. In Holton's token economy, individual contingency contracts were negotiated with residents, setting forth explicit expectations for all daily behaviors. Individual treatment contracts were negotiated at close and were evaluated on the basis of behavioral changes in treatment groups and in daily activity. At Close, performance and privileges were managed informally, and parole recommendations were based on the treatment team's evaluation of the youth's readiness. At the end of the study period, after all attritions, data were available for 517 youths at Close and 466 at Holton. CIES was administered to staff and residents once in August, 1968, and again in September, 1970. A group of institutionalized youth and staff from 69 living units in various parts of the country were used as controls. In 1968, the perceptions of the staff at both schools were similar. Two years later, the greatest change was on the aggression scale in that staff from both

schools perceived less arguing among residents. The Close staff scored significantly higher than Holton staff on the relationship dimension, indicating that Close staff saw the institutional milieu as fostering the residents' free and open expression. Close staff also scored higher on treatment program, implying that they felt that the program was beneficial for residents. Staff were consistently more positive than residents in evaluation. Scores of residents in 1968 were similar. Differences in 1970 were due mostly to the different perceptions of Holton subjects. In 1970, Close residents were more positive in their perceptions of their treatment program, had a more positive relationship with staff, and saw more order and clarity in their institution than did residents at Holton. Dissatisfaction of Holton residents was reflected in their higher aggressiveness score. Preliminary findings showed that subjects paroled from both programs had significantly lower parole violation and recidivism rates than comparable youths released from other institutions. (5 references)

204. Jones, Mary A.; Neumann, Renee; and Shyne, Anne W. *A Second Chance for Families: Evaluation of a Program to Reduce Foster Care.* New York: Child Welfare League of America, 1976.

Reported is an evaluation of the effectiveness of personal social services to the families of endangered children in preventing or reducing foster care. In New York State during 1974, a number of social work teams were established in several private and public child agencies in New York City, Westchester County, and Monroe County. Subsequently, a total of 549 families needing service were randomly assigned for service, 373 to the experimental program, and 176 to control. Family cases were labeled as preventive or rehabilitative. Services data were kept which showed that experimental families received almost twice the interviews and other contacts as did control families. Further, a substantially higher percentage of experimental families received counseling, assistance, medical services, and a number of other social and health services. At the cutoff date for gathering data which followed an average of 8½ months of service, 72 percent of the experimental children were at home, compared to 61 percent of the control. Of the children at home initially, which numbered about half of each group, 93 percent of the experimental and 82 percent of the control groups were home at the end. Of children in care originally, proportions returned home were 47 percent and 38 percent respectively for experimental and control groups. Experimental children spent 35 percent of the project days in placement, while control children spent 43

percent of project days in placement. All of these differences were significant except the difference in proportion returned home. Other data, such as changes in functioning and current well-being, also showed differences favorable to the experimental group. A search among 30 independent variables which might have explained these differences was not productive. Very few of the 30 variables, including a number of "problem situation" factors, were correlated with outcome above .2. Multiple correlation of 16 selected independent variables with outcome accounted for only 26 percent of the variance in the outcome measure. The so-called "services" variables proved to be about as important as "background" and "problem situation" variables in explaining outcomes. In particular the worker-client relationship was one of the more noteworthy factors, although all contributions to explanation were modest. The demonstration service cost approximately $1,200 per study child, as compared with estimated annual foster care cost of close to $6,600 per child. Cost of treatment was not offset by presumed savings during the study year but would have been offset two to three times over if the children had all stayed in care the average 3 to 4 years. Observations of administrators and social workers emphasize that service should be offered on a decentralized basis with a rehabilitative focus. Above all, a great effort was necessary to gain confidence of the families and organize service, but supplementary services such as day care and homemaker service were considered as essential as casework counseling. Further, the caseworkers operated in "service broker" and "advocacy" roles, and these were considered just as important as the individual counseling.

205. Jones, Maxwell. Community care for chronic mental patients. The need for a reassessment. *Hospital and Community Psychiatry*, 26(2): 94-98, 1975.

The national policy of replacing State hospitals with minimal care facilities and mental health centers is critically examined. Several observations are made in developing an argument for a new kind of social arrangement to care for chronically ill and dependent groups who continue to be neglected. The community mental health centers movement is interpreted as a political and economic phenomenon to justify reduction of mental hospital populations by shifting of attention to preventive treatment of younger and more active target groups. Evidence that chronically ill and aged ex-patients are languishing in custodial care is briefly reviewed. The central fact ignored in recent policy development is that economic, political, and professional constraints all work against ade-

quate care for "madness, senility, imbecility, and helpless dependency." A new philosophy of care for dependent groups is needed. Several principles are suggested for reappraisal of recent policy. First, hospitals could become centers for active, community-based treatment of small patient loads. Second, the medical or hospital principle of organization where not appropriate should be abandoned, especially for long-term care. Patients should be permitted to develop ties of dependency and loyalty. Third, hospital and local services should be integrated. Fourth, a systematic plan for hospital alternatives needs developing. Finally, legislators need to accept public responsibility for the chronically dependent. A community or village organization to care for chronic dependent groups while optimizing participation and self-direction is suggested.

206. Jones, Reginald L. Student views of special placement in their own special classes: A clarification. *Exceptional Children*, 41(1): 22-29, Sept. 1974.
207. Jones, Reginald L. The hierarchical structure of attitudes toward the exceptional. *Exceptional Children*, 40(6): 430-435, 1971.
208. Jones, Reginald L.; Marcotte, Marcia; and Markham, Karen. Modifying perceptions of trainable mental retardation. *Exceptional Children*, 34(5): 309-315, 1968.
209. Jones, Reginald L., and Sisk, Dorothy A. Early perceptions of orthopedic disability. *Exceptional Children*, 34(1): 42-43, Sept. 1967.
210. Klason, Leon. Kosher meals-on-wheels. *The Gerontologist*, 14(1): 33-34, 1974.
211. Kane, Joseph H. An institutional program for the seriously disturbed delinquent boy. *Federal Probation*, 39(3): 37-44, 1966.
212. Kaplan, Jerome, and Ford, Caroline S. Rehabilitation for the elderly: An eleven-year assessment. *The Gerontologist*, 15(5): 393-397, 1975.
213. Karen, Robert I., and Bower, Ronald C. A behavioral analysis of a social control agency: Synanon. *Journal of Research in Crime and Delinquency*, 5(1): 18-34, 1968.
214 Kavaler, Florence, and Swire, Margaret R. Health services for foster children: An evaluation of agency programs. *Child Welfare*, 53(3): 147-157, 1974.
215. Keener, Mary Lou. The public health nurse in mental health follow-up care. *Nursing Research*, 24(3): 198-201, 1975.
216. Keith, Pat M. Evaluation of services for the aged by professionals and the elderly. *Social Service Review*, 49(2): 271-278, 1975.

A study of the degree of congruence between professional and client preferences for additional health and social services

for the elderly is presented. Interviews were conducted with 124 noninstitutionalized individuals 65 or over. Respondents were randomly selected blacks in a midwestern city of approximately 30,000. Professionals supplying opinions by questionnaire included 22 physicians, 24 ministers, 4 social workers, and 4 public health nurses. The elderly and the professionals were asked to evaluate priorities for the provision of additional services and facilities in 23 areas, on a scale from 1 (high priority) to 6 (low priority). The ratings for each service were summed, and means were calculated for both the professionals and the elderly. To assess the degree of agreement between the two groups on priority needs, a Spearman rank correlation was obtained. The data indicated there is a significant relationship between the rankings of the professionals and those of the elderly ($p < .05$). Both groups agreed that legal aid, transportation, and visitation services are highest priority areas. There was also agreement that assistance in finding housing, handyman service, homemaker-health aides, and information referral services should be among the first 10 priority areas for additional resources. In general, the elderly assigned more importance to supportive services and maintenance activities which would enable older persons to remain in their homes for a longer period of time.

217. Kelly, Francis J., and Baer, Daniel J. Physical challenge as a treatment for delinquency. *Crime and Delinquency*, 17(4): 437-445, 1971.
218. Kelly, James G. Toward an ecological conception of preventive interventions. Ch. VI. In Carter, Jerry W., ed. Research contributions from psychology to community mental health, New York, *Behavior Publications*, 76-99, 1968.
219. Kennedy, John G. Nubian Zar Ceremonies as psychotherapy, *Human Organization*, 26(4): 185-194, 1967.
220. Kent, Donald L., and Hirsch, Carl. Indigenous workers as a crucial link in the total support system for low-income, minority group aged: A report of an innovation field technique in survey research. *International Journal of Aging and Human Development*, 2(3): 189-196.
221. Kirk, Stuart A. The impact of labeling on rejection of the mentally ill: An experimental study. *Journal of Health and Social Behavior*, 15(2): 108-117, 1974.
222. Kistin, Helen, and Morris, Robert. Alternatives to institutional care for the elderly and disabled. *The Gerontologist*, 12(2): 139-142, 1972.
223. Kliebhan, Sister Joan Marie. Effects of goal-setting and modeling on job performance of retarded adolescents. *American Journal of Mental Deficiency*, 72(2), 1967, pp. 220-226.

224. Klein, Malcolm W. Gang cohesiveness, delinquency, and a street-work program. *Journal of Research in Crime and Delinquency*, 6(2) 135-166, 1969.

The results of a 4-year evaluative study of a detached-worker program dealing with delinquent gangs are reported. In 1961, the Group Guidance Section of the Los Angeles County Probation Department launched the 4-year project to test the effectiveness of an intensified version of its standard approach to gang work. The test area was 6½ square miles of lower middle and lower class homes with a largely black population. Four gang clusters, including almost 800 youths aged 13 to early 20s in 21 gangs, were the focus. The program consisted of five workers trying to involve gang members in discussions and activities that might prevent continued involvement in illegal acts. Workers were involved in individual counseling, weekly club meetings, special group activities, parent club meetings, and contacts with significant adults in the community. Workers filled out daily activities forms over a 19-month period, which showed that they spent an average of 38 percent of their time in the office, 25 percent in traveling, 10 percent in meetings and special activities, that 37 percent of total contact time was with youths, 13 percent with parents, and 50 percent with other adults. The weekly club meeting was to transform the gang into a prosocial club orientation and was attended by an average of 17 youths. An average of one activity every 2 weeks per cluster took place with an average attendance of 11 youths. Such activities were seldom used for delinquency prevention. A tutoring program and a remedial reading program, both staffed by volunteers, seemed to have some success, involving 135 youths. The number of daily field contacts per worker was much higher in the test area than in control areas; test area workers had more contacts with community adults, fewer with gang parents, the same with gang members, the same amount of office time, fewer club meetings, more special activities, and lower attendance in meetings and activities. The vast majority of gang members in the test area became probations. Data indicate that Group Guidance resulted in an increase in the number of recorded offenses committed by the gangs, with negative impact at ages 12-15. Project impact was found to be related to programing, worker style, and cohesiveness. Analyses of intercluster differences and specific project events revealed positive relationships between levels of group programing, cohesiveness, and delinquency. The workers were believed to be a source of gang cohesiveness. (40 references)

225. Klein, Mal. Labeling, deterrence and recidivism: A study of

police dispositions of juvenile offenders. *Social Problems*, 22(3): 292-303, 1974.

A study, examining whether the labeling of juvenile offenders by the police, results in an increase in recidivism is described. The records of a sample of 1969 arrested juveniles, the first 100 per department from 18 similar Los Angeles County police agencies, selected on the basis of their high or low diversion rates discovered in an earlier study, were analyzed. "Diversion rate" is the proportion of arrested juveniles who are released by police rather than inserted further into the juvenile justice system. Background data, offense data, and departmental dispositions were taken from these records for all of 1969 and 1970, yielding recidivism and related data for up to a 2-year followup period. Statistical analyses of these data indicate that police departments with high rates of juvenile diversions do not yield different recidivism rates than those with low diversion rates, unless comparisons are made between first and multiple offenders. When such comparisons are made, high diversion departments had lower subsequent recidivism rates for first offenders than multiple offenders, while low diversion departments did not exhibit such differences—a finding that tentatively supports labeling theory.

226. Koff, Theodore H. Rationale for services: Day care, allied care, and coordination. *The Gerontologist*, 14(1): 26-28, 1974.

227. Kostick, Abraham. A day care program for the physically and emotionally disabled. *The Gerontologist*, 12(2): 134-138, 1972.

228. Krause, Elliott A. After the rehabilitation center. *Social Problems*, 14(2): 197-206, 1966.

A methodological critique is presented of outcome studies which follow patients from rehabilitation centers. The arguments also apply to health and welfare settings in general. The key to this critique is that rehabilitation center staff members depend on professionals in other organizations, clients' families, and the economy for "success." Therefore, percent employed is not a valid measure of center success. Because the center's aim in many cases is simply assessment of a client, reemployment is not even an intended outcome. Further, the referring counselor controls case planning since he must approve any expenditure; also he may be the placement counselor. The referring counselor is under pressure to rehabilitate many in his caseload, to carry a large caseload, and thus to accept only promising clients. Again, percent employed would not be a relevant index. Third, the clients' families and neighborhood often impose expectations for poor or deviant role performance. Fourth, the community and economy can con-

strain or even prevent reemployment. In conclusion, it is noted that fiscal accountability, not a desire to understand rehabilitation processes, accounts for the demand for high rates "rehabilitated." The net result of this situation is that "organizations whose manifest function it is to diminish the marginality of selected individuals may thus have the latent function of perpetuating the marginality of whole segments of society."

229. Kramer, Milton, and Young, Calvin. Attitudes and activities in community mental health. *Hospital and Community Psychiatry*, 23(2): 58-61, 1972.

230. Labreche, Gary; Turner, R. Jay; and Zabo, Lawrence J. Social class and participation in outpatient care by schizophrenics. *Community Mental Health Journal*, 5(5): 394-402, 1969.

The extent of utilization of outpatient facilities by persons diagnosed as schizophrenics is examined in relation to social class position and such additional variables as hospital experience, severity of pathology, and marital status. A sample of 213 white males, age 20 to 50, were drawn from the Monroe County (NY) Psychiatric Case Register. The register provided information on all periods of outpatient and inpatient care, providing a longitudinal record of 3 to 6 years' duration of all psychiatric experience for each subject. Other data sources used were two separate and independent ratings by psychiatrists, a social worker's report of an interview with a family member, and a lengthy sociological questionnaire administered by a nonprofessional interviewer. A third psychiatrist with substantial clinical experience scored a 12-point pathology scale (ranging from minimum impairment to marked impairment) for each patient on the basis of the interviewing psychiatrist's symptom check list. The measure of socioeconomic status employed was the Hollingshead Two Factor Index of Social Position. A patient was "in outpatient care" if he was seen by a private psychiatrist or at a psychiatric clinic at least once per month at some time during the 3 to 6 year followup period. A patient was "hospitalized" if he had continuous inpatient care for more than 15 days. Chi-square analysis indicated a significant relationship ($p < .005$) between social class and involvement in outpatient care. This relationship was not significant for the minimally or moderately impaired levels of psychiatric impairment, but was highly significant ($p < .001$) for the markedly impaired subjects. Of those in the highest social status grouping, 75 percent have received outpatient treatment, while 24 percent of the class IV individuals and only 11 percent of those in class V have been so involved.

231. Lamb, H. Richard. Chronic psychiatric patients in the day hospital. *Archives of General Psychiatry*, 17(5): 615-621, 1967.

232. Lamb, H. Richard. Release of psychiatric patients into the community. *Archives of General Psychiatry*, 19(1): 38-44, 1968.

A study is presented which was undertaken for four basic reasons: (1) to compare the total chronic population from one county at the beginning and end of an 18-month period; (2) to determine how many of the chronic patients present in the hospital at the beginning of the study were still in the hospital 18 months later and how many were living in the community; (3) to study the factors which increase or decrease the likelihood of chronic patients leaving the hospital; (4) to examine the outcome of the patients discharged into the community in terms of living situation and employment and to see whether age, sex, and length of hospitalization affect the choice of a living situation and the degree of productivity in the community after discharge. All patients from San Mateo County in residence at Agnews State Hospital on September 15, 1965, were surveyed, and data were collected on all those 60 years of age and under. All patients in this group who had been continuously hospitalized for a year or more or had spent at least half of the past 2 years in the hospital were identified as chronic patients. A second survey was done 18 months later on March 15, 1967, and again all chronic patients 60 years of age and under in the hospital were identified, and data were collected. At the end of the 18-month period, a further determination was made of what had happened to the patients in the original survey. The chronic population became smaller in size during the 18-month period. As a whole, the chronic population became older in both chronological age and length of hospitalization, with an increasing percentage of patients having an organic, rather than functional, problem. While 43.9 percent of the chronic patients from the initial sample with functional diagnoses were in the community at the end of the 18-month period, only 19.4 percent of the patients with organic diagnoses were in the community. Sex and age are not significant factors in determining if a patient is likely to remain in the hospital or be in the community. Outcome for patients is significantly related to length of hospitalization ($p < .001$). The longer the patient had been hospitalized, the less likely he was to return to the community and the more likely to remain in the hospital. Length of hospitalization was also significantly related to the living situation of a patient who returns to the community ($p < .02$). The longer the patient had been hospitalized, the less likely he was to return and live alone or remain with family and the more likely he was to be living in a semi-institutional setting like a boarding or family care home or a halfway house. Only 4 of 56 patients who were in

the community at the end of the 18-month followup period were employed full time. However, 15 were engaged in sheltered employment or training, 3 did volunteer work, and 7 were housewives. The remaining 27 were unemployed.

233. Lang, Priscilla A., and Oppenheimer, Jeanette R. The influence of social work when parents are faced with the fatal illness of a child. *Social Casework*, 49(3): 161–166, 1968.

234. Latham, Glenn, and Hofmeister, Alan. A mediated training program for parents of the preschool mentally retarded. *Exceptional Children*, 39(6): 472–473, 1973.

235. Lawton, Alfred H. Medical and physiological aspects of a treatment program for the mentally retarded aged. *The Gerontologist*, 6(3): 139–142, 1966.

236. Lawton, M. Powell. Supportive services in the context of the housing environment. *The Gerontologist*, 9(1): 15–19, 1969.

Presented are the results of a 3-year study at the Philadelphia Geriatric Center (PGC) dealing with onsite housing services for the elderly. The PGC interviewed samples of applicants to seven housing sites just prior to moving in and again a year later. Also, samples of tenants in seven housing sites with a greater variety of onsite services were also interviewed. Four samples of elderly living in the community who had not applied to planned housing were interviewed. Sample sizes averaged 100 in the 18 groups, though the number responding to specific questions varied from 70 to 1700. Medical services were valued above all others for all of the groups. With other types of services, the desire for the service seems to be a function of what one has: Tenants in sites without services had a low need for them, while tenants receiving services did not wish to give them up. In the samples interviewed twice, the need for medical services increased slightly in a year, while the need for meal services decreased. Factor analysis implies that the wish for meal, housekeeping, social, and recreational services seems to be related more to affluence than desperate need. Desire for medical services correlates with poor health and low morale. The utilization rate of services where they are offered varied widely by site and by service. In two sites, 69 percent of the tenants saw the physician at least once during the preceding year. In three sites, offering a daily hot lunch, 23 percent of the tenants used the service at least once weekly. When applicants know that services exist, and when the prospective tenants are economically able to choose where they live, services are apparently a potent drawing factor. Comparisons between sites show that applicants to sites without services are more competent than applicants to sites with services. (1 reference)

237. Lawton, M. Powell; Patrick, Beverly; and Eleban, Morton H. The ecology of adaptation to a new environment. *The International Journal of Aging and Human Development*, 7(1): 15-26, 1976.

238. Lazar, Alfred L.; Gensley, Julianna T.; and Orpet, Russel E. Changing attitudes of young mentally gifted children toward handicapped persons. *Exceptional Children*, 37(8): 600-602, April 1971.

239. Lazar, Alfred L.; Orpet, Russel E.; and Revie, Virgil A. Attitudes of young gifted boys and girls toward handicapped individuals. *Exceptional Children*, 38(6): 489-490, 1972.

240. Lebowitz, Barry D., and Dobra, John L. Implementing an income strategy for the elderly: Studies in organizational change. *International Journal of Aging and Human Development*, 7(3): 255-268, 1976.

241. Leonard, Lois E., and Kelly, Ann M. The development of a community-based program for evaluating the impaired older adult. *The Gerontologist*, 15(2): 114-118, 1975.

Described is an interdisciplinary, community-based program for the evaluation of the impaired older adult for whom State mental hospitalization is being contemplated. The Geriatric Evaluation Service (GES) was part of the Bureau of Patient Care, Baltimore County Department of Health. The model patient was white, middle class, had a local physician and a concerned family who had contacted at least one resource before being referred to GES. Of the 465 persons screened by the program, 27 percent were referred by State hospitals, 14 percent by family and friends, and 10 percent by the health department. After screening, 47 percent remained in their own setting, 26 percent moved to nursing homes, 15 percent went to the State hospital, 6 percent were sent to a private psychiatric hospital, 4 percent went to general hospitals, and 2 percent were placed in foster care. A geriatric clinic in a general hospital was established for patients requiring further diagnostic tests as was a clinic in a community mental health center to determine whether hospitalization could be avoided. Patients who required brief, intensive psychiatric care were referred to a private psychiatric hospital. After social and medical evaluations, the social worker and physician made recommendations to the patient and family. Usually, it was possible to find a workable plan. The older person would, when able, participate in the decision. The primary thrust of the program was to maintain patients, when possible, in the community. (19 references)

242. Lerman, Paul. Individual values, peer values, and subcultural delinquency. *American Sociological Review*, 33(2): 219-235, 1968.

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An attempt is made to describe subcultural delinquency adequately so that the object of the explanation is similar for all theories. In a survey of 555 youth from New York City's Lower East Side, all youth reported ability to get good grades as the most important value choice. Boys were less attracted to this conforming value than girls. Attraction to a deviant value began early and increased at 12–13 years of age. Attraction to a deviant value is likely to shift to a conforming value. With increasing age, the job world tended to replace school as the primary value orientation. Youth attracted to a deviant value were likely to seek out peers sharing this orientation. Admissions of misconduct were highest among older boys attracted to deviant values, whose associates support deviant values, and who are ambivalent toward good grades.

243. Lerman, Paul. Part One, The community treatment project. *Community Treatment and Social Control.* Chicago: University of Chicago Press, 1975. pp. 19–104.

A 1971 reassessment of evidence for success of California's Community Treatment Program (CTP) for juvenile offenders leads to the conclusion that the program did not achieve any of its goals. Begun on an experimental basis in 1961 and carefully documented, CTP was a true "in lieu" program where subjects were randomly assigned to either the community-based CTP or to the conventional training school and parole program. The CTP program was designed to provide an intensive period of treatment lasting about 8 months, then a less intensive transitional period, then a minimum supervision period. The diagnostic scheme-interpersonal maturity or "I-level" measured degree of complexity in self-perception and pattern of responding to the world. The typology was used to design differential treatment responsive to individual delinquents. In implementation, however, intensive treatment was greatly extended and temporary detention came to be a common "treatment" method. The CTP claims of success were based on correctional official behavior, not on "juvenile" or offender behavior, in that outcome measures used, such as reported offenses and parole revocations, actually demonstrated rates of official decisionmaking. Further, because of the lengthening of intensive treatment, CTP was about half again more expensive than the standard treatment. The increased use of temporary detention led to the paradox that most "treatment" under CTP was actually detention. From this analysis, four kinds of issues may be defined: the need for outcome criteria which reflect juvenile problematic behavior, not adult official behavior; the semantic and professional confusion resulting from designation of punishment as "treatment"; problems of freedom and due process raised by wide-

spread use of detention as a "treatment" device; and the unintended result from the CTP experiment that statewide adoption of temporary detention as policy may have greatly raised costs of juvenile correction.

244. Lerman, Paul. Probation subsidy. Part two. *Community Treatment and Social Policy: A Critical Analysis of Juvenile Correction Policy.* Chicago: the University of Chicago Press, 1975. pp. 105–225.

An independent reexamination of California's Probation Subsidy Program, 1965–1971, shows that it failed in its implicit goals. That is, the program reduced first admissions to correctional State institutions from participating courts, but at the same time total juvenile detention and total juvenile correctional costs rose sharply. Beginning in 1965, the Probation Subsidy Program paid over 50 million dollars in State funds to participating counties on the basis of their reduction in rate of first commitments to State juvenile institutions. First commitment rates were cut in half, but the number of beds increased, length of institutional stay increased, ratio of staff to wards increased, and use of State institutions broadened. These changes in operation of State facilities are "unintended systemic consequences" of the new program. These changes, which resulted from probation subsidy, caused State costs for juvenile correction to go up, not down. Changes in county operations also occurred, traceable to the new program. Temporary detentions per parolee increased greatly, time on parole increased, and short-term detention was substituted for parole revocation. In general, reduced first commitments were accompanied by small increases in days of institutionalization per youth and large increases in costs, when State and county operations were combined. A "strategy of search" is suggested by this analysis, reduction in discretionary power of correctional officials while searching for less extreme and less costly forms of control and treatment.

245. Lerner, Robert, and Blackwell, Barry. The GP as a psychiatric community resource. *Community Mental Health Journal,* 11(1): 3–9, 1975.

246. Levine, David. A cross-national study of attitudes toward mental illness. *Journal of Abnormal Psychology,* 80(2): 111–114, 1972.

Whether or not there is a close relationship between attitudes concerning mental illness in a community and the social-political climate of that community is examined. The Opinions About Mental Illness Scale, a 51-item questionnaire yielding factor scores on authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, and interpersonal etiol-

ogy, was administered to samples of students, physicians, nurses, and police in Great Britain, Czechoslovakia, and West Germany. Comparing the mean opinions about mental illness factor scores, the results indicate that (1) there are substantial national differences in attitudes toward mental illness; (2) these attitudes appear to be part of a person's general orientation to social issues, rather than a narrow function of his concept of mental illness; and (3) in a community climate characterized by an authoritarian social-political structure, one can expect to find authoritarian and socially restrictive attitudes toward the mentally ill. (4 references)

247. Levinson, Robert B.; Ingram, Gilbert L.; and Azcarte, Eduardo. "Aversive" group therapy: Sometimes good medicine tastes bad. *Crime and Delinquency*, 14(4): 336-339, 1968.

An experiment using "treatment" as "punishment" is reported. Capitalizing on the negative reactions of many inmates toward group therapy, psychologists at the National Training School for Boys in Washington, D.C., established a special therapy group mandatory for anyone repeatedly committed to segregation due to poor behavior. The object of the program was to decrease the number of commitments to the segregation unit and thereby increase the amount of time the inmate would be exposed to correctional treatment. To be eligible for the group, a boy had to have been segregated at least once each montn for 3 successive months. The groups were held once weekly for 1-1/2 hours and were mandatory until the boy had 3 successive months without going to segregation. The number of participants was kept at eight by replacing leaving members with new ones. Seventeen inmates completed at least 3 months in group therapy; 11 of them earned their way out. It took an average of 5.9 months to earn out of the group. Of these 11 boys, 3 had no misconduct reports for 6 months following therapy, and 6 were placed on work release. Though the number of boys on the program was small, it produced evidence that this approach might be worth further investigation. (2 references)

248. Levis, Donald J., and Carrera, Richard. Effects of ten hours of implosive therapy in the treatment of outpatients: A preliminary report. *Journal of Abnormal Psychology*, 72(6): 504-508, Dec. 1967.

249. Levitan. Teresa E. Deviants as active participants in the labeling process: The visibly handicapped. *Social Problems*, 22(4): 548-557, 1975.

250. Lewis, Sandra. A patient-determined approach to geriatric activity programming within a state hospital. *The Gerontologist*, 15(2): 146-149, 1975.

251. Linn, Lawrence S. Social characteristics and social interaction in the utilization of a psychiatric outpatient clinic. *Journal of Health and Social Behavior*, 8(1): 3–14, 1967.
252. Linstrom, Robert C.; Ernst, Theodore; and Southwood, Virginia. A linkage point for health and social services. *The Gerontologist*, 10(2): 107–110, 1970.
253. Linton, Thomas E. The European educateur program for disturbed children. *American Journal of Orthopsychiatry*, 39(1): 125–133, 1969.

    The role of "educateur" in treatment of disturbed children in northern Europe is explicated, and both treatment facilities and training programs are summarized as well. The educateur role is to be the child's model and companion, directing and sharing activities with him all day long. The educateur lives in the children's institution or facility and provides structured activities of recreation, gymnastics, work, learning, and so forth. The activities give structure to the day of the 8 to 10 children in his group, but also serve as a medium for emotional involvement and personality change. The educateur does not work through verbal or insight therapy. Other roles, such as psychiatrist and social worker, are filled in much the same way as in the United States. Educateurs are used in recreation programs, street clubs, and the like, as well as in treatment institutions. Educateur training has been developed for 20 years in France, and there are 26 training colleges, graduating 3 to 4 thousand per year. The 3-year course is not dominated by any one mental health discipline and consists of classes and internships, half and half. Craft, vocational, and athletic techniques are a significant part of training. It is noted that the United States is unique among advanced nations in the lack of integration of child treatment facilities with social services, vocational training, and other segments of community life.
254. Lipton, Helene L., and Suarstad, Bonnie L. Parental expectations of a multi-disciplinary clinic for children with developmental disabilities. *Journal of Health and Social Behavior*, 15(2): 157–166, 1974.
255. Loeb, Armin; Wolf, Abraham; Rosen, Marvin; and Rutman, Irvin D. The influence of diagnostic label and degree of abnormality on attitudes toward former mental patients. *Community Mental Health Journal*, 4(4): 334–329, 1968.
256. Loew, Clemens A., and Silverstone, Barbara M. A program of intensified stimulation and response facilitation for the senile aged. *The Gerontologist*, 11(4): 341–347, 1971.

    Described is a study which investigated the effects of a program of intensified sensory input and response facilitation

DOCUMENT RESUME

ED 232 075 CG 016 769

AUTHOR Taber, Merlin A.
TITLE The Social Context of Helping: A Review of the Literature on Alternative Care for the Physically and Mentally Handicapped. Studies in Social Change Series.
SPONS AGENCY National Inst. of Mental Health (DHHS), Rockville, Md.
REPORT NO DHHS-ADM-80-842
PUB DATE 80
CONTRACT 278-76-0030(SM)
NOTE 260p.
AVAILABLE FROM Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.
PUB TYPE Reference Materials - Bibliographies (131)

EDRS PRICE MF01/PC11 Plus Postage.
DESCRIPTORS Annotated Bibliographies; Helping Relationship; Innovation; *Mental Disorders; Mental Retardation; *Physical Disabilities; *Program Development; *Program Effectiveness; Social Agencies; Social Attitudes; *Social Environment; Social Values; *Therapeutic Environment

ABSTRACT

This document reviews literature from 1966 to 1976 concerning alternative social contexts (social settings rather than physical settings) for helping the physically and mentally handicapped. The introduction discusses the focus of the review, the relevance of the topic for policy development, and the research methodology employed in the study. A list of the 38 journals reviewed is provided. Chapter 1 reviews innovative approaches used in traditional settings; new institutional forms; and the creation of new, small social systems for specific helping goals. Chapter 2 reviews the evaluation of standard therapeutic techniques and goals; treatment and care as a self-perpetuating activity; and the placement of handicapped or disturbed people in special settings. Chapter 3 deals with social interactions and relationships in alternative helping contexts. Chapter 4 reviews values and attitudes toward those who need help; labeling; and values in the contexts of helping. Chapter 5 reviews essays, discussions, and research reports relevant to social policy. Chapter 6 presents the assessment and personal conclusions of the author regarding the literature reviewed. A subject index and an annotated bibliography of 455 citations, selected from the larger review, are also included. (WAS)

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ED232075

THE SOCIAL CONTEXT OF HELPING: A REVIEW OF THE LITERATURE ON ALTERNATIVE CARE FOR THE PHYSICALLY AND MENTALLY HANDICAPPED

Studies in Social Change Series

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

This monograph is one of a series of studies concerning social change. The series is being sponsored by the Division of Special Mental Health Programs, National Institute of Mental Health, to encourage the utilization of social science knowledge in public policy discussions.

The monograph was written by an authority on research in the area of social problems under contract number 278-76-0030(SM) from the National Institute of Mental Health. The opinions expressed herein are the views of the author and do not necessarily reflect the official position of the National Institute of Mental Health.

DHHS Publication No. (ADM) 80-842

Printed 1980

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Foreword

Who will care for those who cannot care for themselves? This crucial question is faced by every society at every period of its development. How well it is faced is a measure of the society's social functioning at a particular time.

During various periods in American history different groups have been designated as caretakers for the physically and mentally ill, the mentally retarded, the social deviant, the very young, and the frail elderly. In the 18th and the early 19th centuries the family was romanticized as the loving and effective caretaker of all those who could not care for themselves. And, the family was expected to cheerfully and effectively tend for and control all members.

Large public institutions for care of the poor and care and education of the handicapped did not come into being until the 1820s. Their purpose was to protect these individuals from the trials of strenuous everyday existence, to change their behavior, and also to protect others from their behavior. It was felt that the handicapped, their families, and their community would all profit by segregated environments.

Though public institutions grew, their populations changed over the next 100 years—fewer poor and fewer children were housed in them, and more physically and mentally ill, retarded, and elderly were housed in them. In more recent years, the effectiveness and humaneness of these institutions have been openly and hotly debated. Their therapeutic abilities have been challenged, and they have been charged with denying an inmate dignity, freedom, and the comfort of his fellow man.

As large State-administered institutions increasingly came under questioning in the 1960s, and as legislators were encouraged by their constituencies to empty these institutions, alternative forms of helping, situated in the community, but seldom in the family, proliferated. These new forms included community mental health centers, day and residential care arrangements for the chronically ill, the retarded, the delinquent, dependent children, and the frail elderly. These new care environments tend to be smaller, more open, and in closer proximity to the general social environment.

With this rapid and widespread move in the United States toward bringing back into the community those populations who have in

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the last 150 years been given social or correctional treatment in large institutions, it becomes crucial to look at what is known about various kinds of alternative community care and new forms of institutional and family care. There is actually little known. The importance of this monograph is that it brings together 10 years of research on differing environments, in terms of the social participation allowed the individual, specific care provided, and feelings of the care giver and the care receiver about the care. The review also focuses on the interrelationships of care-giving institutions and the ways in which they communicate and cooperate. Care contexts are related to six major social categories of persons needing help: severely physically handicapped persons, the mentally ill, the mentally retarded, the delinquent, dependent children under 18 years of age, and the frail elderly.

Study of what is known about the strengths, the weaknesses, and the problems of various social contexts of helping is essential for the planning of future social environments, environments which will foster human relationships as well as necessary supportive services. Such study is designed to aid the policymaker, the administrator of services, and the public in their choices for people in need. The choices themselves are critical for the mental health of all concerned—for the recipients of care and for those who care for and about these individuals.

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INTRODUCTION

With the decline of both family care and large-scale institutional care of those who are unable to provide for themselves, a number of alternative service solutions have been developed. For 150 years, a policy of exclusion and custody was society's provision for those unable to care for themselves. Now there is a ferment of new ideas for helping the socially, mentally, and physically handicapped. The 1960s saw beginnings of comprehensive community mental health centers, diversion programs for juvenile offenders, the "normalization" of lives of mentally retarded, and other similar initiatives. In the 1970s, however, many questions have arisen about the feasibility and even the advisability of integrating into community life those who need help. Obstacles include residential code enforcement, objections by State employee unions, professional aversion to serving the chronically ill, and lack of funds. Further programing and policy development badly need a sound knowledge base. Particularly needed is better knowledge about the social situations in which long-term care is being provided, and the interaction between professionals and clients in those settings.

Focus of the Literature Review

Focus of this review of the literature on helping, 1966 to 1976, concerns alternative contexts of helping for those unable to provide for themselves. The term "context" refers to the social setting in which help is given, rather than the physical setting. The social context for help (or setting or situation) is interpreted as the set of roles in the immediate social situation; for example, "attendant," "nurse," "social worker," and "guard." Roles are not only the positions in a social structure but also the expected and accustomed behaviors of persons occupying these positions. Roles of helpers carry certain values and dispositions in relation to those being helped and vice versa. The concept of a social context or social situation in which help is given calls attention to the complete network of social relations managed by those who are helped. The concept of social context may be contrasted with the professional

view of a "helping relationship" or "professional relationship." Professional theories emphasize mainly the professional and to some extent the behaviors prescribed for those being helped. The focus of this review on social context is on the helping relationship as a part of the client's social experience, not necessarily the dominant feature in the life of the client. It is assumed that professionals' efforts to change clients may be either supported or defeated by other aspects of the social situation.

Knowledge about "alternative contexts for helping" includes several areas of attention: formal organization and structure; effects of those contexts on those being helped; quality of social relations in alternative helping situations; social attitudes and values toward alternative contexts; and the relations between these alternative contexts for help and broader society. These five aspects of the social context guided the literature search and have also been used to organize this report.

The definition of "those unable to provide for themselves," for this review, is a broad one, bringing together material concerning a number of different client groups. The review encompasses almost all the major social categories of persons who have traditionally been given social or correctional treatment in large State-administered institutions. These groups are dependent children under 18 years of age, juveniles judged to be delinquent, mentally ill adults or children, mentally retarded adults or children, the frail elderly, and severely physically handicapped persons.

For every one of these six target populations there has been a movement toward interrupting the policy of long-term care in isolated institutions. These movements have gone under various names, for example, "diversion" of juveniles from training schools, "normalization" of the lives of mentally retarded, and "community care" for the mentally ill. The focus of this review is not on care and help to these groups in traditional State institutions or family settings, but rather on the knowledge developed from provision of help and care to these groups in new alternative settings.

There is, in fact, little systematic research or experimentation which fits this focus. There is a massive literature on treating, helping, influencing, and managing these "dependent" groups of people. This massive literature, however, is tailored to the particular social science discipline or professional belief systems within which the investigators worked. That is, the psychiatric literature concerns what the psychiatrist does and the patient's reactions. There is little attention to the social situation and the role set of the patients. The same is true for the literature of clinical psychology, social work, and other helping professions. The scientific literature of academic disciplines, e.g., sociology or anthropology, contains little research on helping situations; statements about the social

situation of those needing help are based on logical inference from accepted theories, not on empirical observation.

As the actual literature search got underway, the decision was made to maintain a broad focus, identifying all research reports, essays, and so on which bear on the topic, whether or not they were undertaken primarily to illuminate this particular topic.

Policy Relevance of This Review

In the 1970s, the United States is at midpoint in a major change in helping those who are unable to provide for themselves. A policy of exclusion and custody is gradually being replaced by a policy of normalization and social development.

The phrase, "a policy of exclusion and custody," is used to describe the rise of State institutions and extensive reliance on them from the 1830s through World War II. The specialized institution was invented in the first half of the 19th century as a humane reform. In the 1700s, those who needed help were relegated to jails, poorhouses, or county farms. The new State institutions of the 1800s were specialized so that their staffs could become experts in helping one target group: the mentally disturbed, or the blind, or dependent children, for example. The isolated location of these institutions was not primarily motivated at first by political and fiscal considerations which later became prominent. As a few historians have pointed out, the notion of "asylum" was a romantic but still very real positive theme for Americans of the early 19th century. The idea was that it would be humane to set aside special locations, or even to create special communities such as "colonies" for the feeble minded, where those who need help could have a higher quality of life. Accustomed as we are through 25 years of reform literature, lectures, and movies to think of "the asylum" as a sink of human degradation, it is easy to overlook the fact that these State institutions represented a major reform in human service. Many of their staff members were dedicated and competent people. The State institutions provided relief and a better life for millions of families during the 150 years of their ascendency as instruments of public policy for those unable to live independently.

The policy developed since World War II is termed "a policy of normalization and social development" to emphasize twin themes of social integration as against isolation, and social development as against custodial stagnation. There is now a growing cynicism about desegregation and disenchantment with its effects. In the field of mental health, for example, the fiscal problems of capital development, the profit potential interests of new psychotropic drugs, and the proprietary interests of the nursing home industry

have been three factors which have contributed more to deinstitutionalization than ideals of "normalization and social development." The relative political influence of positive ideals of integration and help as against fiscal interests, both government and private, probably cannot be disentangled. In any case, all advanced countries have enacted a policy of normalization and social development. The key tenet of this policy is that those who cannot provide for themselves must be helped, not to lead a separate life from society, but to take part in society. The method of doing so is not to provide care and to supplement functioning of those who need help as though they were inanimate objects, but rather to help them improve their own capabilities. This policy, however imperfect its execution, has already cost several billion dollars in public expenditure and has caused the redirection of the lives of thousands of handicapped people and the careers of thousands of professionals. State institutions have been depopulated to a significant extent. The dramatic rise in public employment at State and local levels, much larger than the rise in employment at the Federal level, is accounted for in large part by programs supposed to care for and help those unable to provide for themselves.

The relevance of the literature review at this time is to ask what has been learned about deliberate design and creation of positive social milieux in 15 years of gradual shifts in programs and populations. The traditional policy of institutionalization and exclusion was criticized because it depersonalized those who needed help. Do present social environments avoid that depersonalization? The traditional policy of institutionalization was also criticized because of its high cost. Are current contexts, which supposedly enlist family and community to help provide for those who need help, more economical? Are those being helped actually more integrated in community life? The traditional policy of exclusion was criticized because State institutions, called "hospitals" and "schools" and "reformatories," were clearly harmful and not helpful to the health and welfare of their residents. Do the newly created, smaller, and local settings have a positive effect on personality and social functioning and health?

Social Science Knowledge for Policy Development

The social sciences have played little role in criticizing or in leading the major policy shift toward normalization and social development. Ironically, medical, fiscal, and political aspects of this policy change have received more scholarly attention than the basic question of social situation. There is a large literature, for

example, on use of psychotropic drugs. The problems of intergovernmental financing have spawned a significant body of literature of research, comment, and criticism. The fields of architecture and design have responded quickly to the challenges and opportunities in designing new living situations for handicapped older people, community homes for the retarded, and special physical environments for other groups. But the social relations in the new, alternate, care-giving settings, which would seem more crucial than chemical, fiscal, or physical considerations, have not been subject to a comparable process of criticism and analysis.

The literature of the helping professions contains many references to alternative forms of care, with attention usually on helping technique, not on context. Among helping professions, especially those of lower status, systematic research is rare, but there is an extensive literature of comment and recounting of experiences in community-based helping.

The lack of attention by social scientists to alternative contexts for care was a prime motivation for this review. The literature review indicates that the social sciences have not studied and analyzed the helping situations to any significant degree.

The areas of knowledge about social contexts for help, as defined for this review, were determined before the review was made. The classification is a prospectus for needed knowledge, not a set of categories found in this review. In fact, several of the defined areas were not well covered in the literature. There was not a substantial or adequate basis of research and experiment in any of the five areas defined, to permit sound new conclusions. The following description of five areas of knowledge is presented to suggest future agenda for the social sciences. This classification of areas of knowledge is also the principle of organization for this report.

The first area of knowledge is the structure of alternative care-giving situations. What policies and procedures, or technologies of care, are officially adopted in these settings? How many clients are present and how many staff members? On what basis do they receive legal and political sanction, such as tax funds, political advocacy, and personal services, from volunteers and community leaders? All of these questions have been thoroughly explored for the traditional State institutions. We need to have an equally extensive analysis for new alternative contexts of care.

A second area of knowledge is that of effectiveness of the new settings in normalization and social development. If those who need help are residents of their home community, do they, in fact, participate in society more than if they were in a distant institution? Are their levels of social functioning, as well as social participation, greater? Can specific skills or role-playing capabilities enhance functioning and, if so, by what social arrangements? Even though

evaluation research is a highly imperfect science, it is timely to determine the present consensus on effectiveness of new alternative helping situations in reaching their goals.

A third area of knowledge is the basic social science question of social relations in the new context. "Social relations" may be conceptualized as role definitions and role behaviors, as specific observable social behaviors, or in still other ways. Regardless of definition used, it is of great importance to describe and analyze daily face-to-face interactions in the new milieux. For example, do small community-based residences lead to greater frequency and higher quality of staff-resident interaction than those which have been documented in traditional institutions? Are role behaviors of staff in the new settings different from those of traditional settings? Do residents of small community facilities interact with community people or only with other residents?

The attitudes and values held by the general public and by actors in helping situations is the fourth area of knowledge. Do people view day centers for the mentally disturbed as more acceptable than large State hospitals for the mentally disturbed? Would parents rather have a delinquent child in a neighborhood correctional facility than in a distant State training school? Knowledge about values with respect to the helping role is also crucial.

The manner in which new contexts for care relate to each other and to the broader society is a fifth and final area of knowledge. How are persons needing help routed between help situations? What institutionalized techniques of interaction are developing, e.g., between families and daycare centers? Traditional State institutions exchanged virtually no information on persons with the community in which they were located. Does this same isolation continue with new alternative situations for helping? Further development of public policy requires understanding of these interinstitutional mechanisms for exchange of persons, resources, and information.

In summary, this review of literature began with a clear focus on five areas of social science knowledge which are in need of development. The five areas are formal structure, helping effectiveness, social interaction, values, and interorganizational relations. The development of knowledge in each of these areas, 1966-1976, is summarized in chapter 6 of this report.

Method of the Review of the Periodic Literature

Several means were used to identify leading professional and social scientific journals for the period 1966 to 1976. Journals oriented to each of the six target populations were identified,

whether issued by the Government, professional associations, or interest groups. University specialists or Federal government officials who worked in these problem areas were consulted to identify leading journals. Next, relevant professional or scientific disciplines and their journals were identified. Those journals which reported relevant research in professional fields were given preference. The helping professions, scientific disciplines, and fields of practice encompassed were child welfare, developmental disability, clinical psychology, gerontology, nursing, juvenile delinquency, psychiatry, social work, and sociology. In addition, several journals of broad coverage not identified with one discipline or narrow field were included, *Annals of the American Academy of Political and Social Science* and the *American Journal of Public Health and Science*, for example. A complete list of the 38 journals included is shown as exhibit 1.

Exhibit 1

Journals Searched for
Research on Contexts for Helping
July 1966 through June 1976

1. *Aging and Human Development*
2. *American Journal of Mental Deficiency*
3. *American Journal of Psychiatry*
4. *American Journal of Sociology*
5. *American Psychologist*
6. *American Journal of Public Health*
7. *American Journal of Orthopsychiatry*
8. *American Sociological Review*
9. *Annals of the American Academy of Political & Social Science*
10. *Archives of General Psychiatry*
11. *Child Care Quarterly*
12. *Child Development*
13. *Children*
14. *Children Today*
15. *Child Welfare*
16. *Community Mental Health Journal*
17. *Crime and Delinquency*
18. *Delinquency Prevention Reporter*
19. *Exceptional Children*
20. *Evaluation*
21. *Federal Probation Reporter*
22. *The Gerontologist*
23. *Hospital and Community Psychiatry*

24. *Human Organization*
25. *Journal of Abnormal Psychology*
26. *Journal of Community Psychology*
27. *Journal of Health and Social Behavior*
28. *Journal of Marriage and the Family*
29. *Journal of Research in Crime and Delinquency*
30. *Mental Retardation*
31. *Nursing Research*
32. *Psychiatry*
33. *Rehabilitation Literature*
34. *Science*
35. *Social Casework*
36. *Social Service Review*
37. *Social Problems*
38. *Social Work*

Target groups covered by this review include virtually all of the major groups receiving residential care and treatment in our society. Adult criminals, the acutely ill, and certain groups of the chronically ill were excluded. Dependent children, the elderly, severely mentally or physically handicapped, mentally ill, and delinquent youth were included. The general focus was new knowledge about social contexts for care and help to those unable to provide for themselves. The five specific areas of knowledge designated to guide the search have been defined above: formal organization, evaluation of effectiveness, social interaction, attitudes or values, and social policy including interorganizational relations.

The scope of this review in terms of the type of report included was broadened soon after the review began. Preliminary scanning of relevant journals indicated a scarcity of systematic research on relevant topics and a scarcity of controlled evaluation of programs in new contexts. Therefore, coverage was broadened to include essays, historical accounts, suggestions for theory development, and other kinds of work, as well as formal research. It was thought that in the absence of a body of research these works would indicate the present state of work in the relevant areas. The following list of types of reports to be included was adapted from a classification of the National Clearinghouse for Mental Health Information:

1. Bibliography
2. Biostatistics or other data compilation
3. Evaluation
4. History (not case history)
5. Instrumentation or measurement problem
6. Legislation or policy
7. Methodology

8. Research
9. Overview, state-of-art research
10. Service or program
11. Statistical or other model development
12. Survey data compilation
13. Theory

Of the 13 categories only two—"Evaluation" and "Research"—were originally to be included. In the final collection of 455 items, less than one-third came under those two headings.

In addition to selections from periodical literature included in the sample, readers will note a number of books, research reports, and monographs included in the bibliography. Through the abstracting work, or through personal communication, the investigator became aware of reports not in the periodical literature having such apparent significance that they should be included. This procedure resulted, of course, in partial coverage, not complete coverage, of program reports, research reports, and evaluations during the time covered. Partial coverage was considered preferable to limiting the review entirely to the survey of periodical literature.

The selection of items from journal issues of July 1966 through June 1976 was performed by the investigator and four assistants who were trained and supervised by the investigator. After some experience, it was found that the question of relevance to the topics, as outlined above, was not ambiguous or difficult. Most research reports on helping did not refer to the social context for helping. Those which did refer to the social context for helping were often set in a context other than the alternative-care situations of interest for this review. Because of the scarcity of relevant research, borderline cases or reports of special interest were included.

After the search and abstracting were completed, the principal investigator reviewed all abstracts and made a final selection for inclusion in this report. Some 600 items were abstracted, and about one-fourth of these were eliminated as being irrelevant or not of sufficient substance. Abstracts of the 455 items cited in this review were then reexamined to determine which abstracts should be included in the final report. About one-half of the abstracts were eliminated because the topic was marginal or because the articles in question reported too few details or explored the topic in too little depth to make the abstract seem worth distributing. The citations without abstracts were retained because of possible value for persons using this bibliography.

This review includes both a descriptive survey of the literature and an assessment of the state of the art. The descriptive survey for each of the areas covered makes up chapters 1 through 5. Analysis by the principal investigator on the state of knowledge, significance

of the work covered, and next steps in research is confined to chapter 6.

Strength and limitations of this approach to surveying the literature should be noted. A strength of this approach is to bring together knowledge developed by different disciplines and by experience in helping different target groups. The survey serves as a guide to work which has been done in several areas relevant to understanding social contexts for help. Students of research or practice in helping can conveniently find research outcomes, ideas, and additional references.

The broad coverage of this review is at the same time a weakness. Incisive and clear-cut conclusions are difficult in a review which covered information on six target groups, gleaned from several different domains of the literature. No one investigator can be expert in all areas. For that reason most of the review is descriptive. Conclusions from the review are confined to chapter 6.

There were still gaps in coverage, because not all journals of interest could be covered. Some target groups such as physically handicapped were less well represented than others. The facilities of the library system of the University of Illinois at Urbana-Champaign, used for the survey, are unsurpassed among public university libraries. The investigator consulted several computer-based bibliographies and used interlibrary loan where necessary. Despite the efforts made to cover every issue of the 38 journals included and to select all of the relevant articles, there were undoubtedly oversights. The survey was not intended to be comprehensive; it is believed that the coverage of journals and selection of articles were sufficiently comprehensive to justify the general conclusions of chapter 6.

CHAPTER 1

NEW CONTEXTS FOR HELPING

What is known about new situations for serving those who need help? This question was the focus of the literature search covering almost 50 professional and scientific journals. The decade 1966 to 1976 saw the implementation of the Federal Community Mental Health Centers Act, nationwide efforts to divert juvenile offenders from incarceration, the beginnings of programs to "normalize" lives of mentally retarded persons and to provide the means for physically handicapped persons to participate fully in the community. These movements had in common the creation of new contexts for helping, different from the traditional State hospital, jail, training school, or classroom. This review was carried out to make known the research evidence from a decade of innovation, experimentation, and reform.

As the review progressed, it became clear that most of the innovations were new approaches to those who need help, carried out in their traditional settings. Even though these reports do not concern "new contexts," the work is relevant to the present review. The programs attempted to change the familiar situation by introducing new activities or services. Some 100 such reports are reviewed under the heading "New Wine in Old Bottles."

A second group of reports concerned the emergence of new institutional forms—new contexts—for helping, caring for, maintaining, and treating those who need help. Three kinds of helping situations were described and assessed in about 60 reports on community-based residential facilities, daycare centers, and home helping. Of these 60-odd reports on new situations, about a dozen were of evaluative research projects where new contexts of help were tested. Under the heading "Old Wine in New Bottles," these three new contexts are described, and the evaluation research summarized.

Ten reports were selected to illustrate the deliberate creation of a new situation, a small social system, for certain defined helping goals. In each of the 10 reports there was a serious attempt to evaluate outcomes. The 10 reports concern a range of conditions

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among mentally disturbed or handicapped persons and, in one case, delinquent youth. Despite a wide range of differences in setting and program, there were striking similarities in the reports. These 10 are described in the last section of this chapter.

Programing Innovations: New Wine In Old Bottles

The most common form of innovation in helping those needing long-term, continued help involved new services or new activities in traditional settings. The traditional settings involved and the number of reports concerning each can be seen in this tabulation:

mental hospital or community hospital	19
State schools or training school	17
classroom	19
community agency or clinic	23
community settings	25

Nineteen of the reports in this survey concerned new programs of service set in a *mental hospital or community hospital*, or similar medically directed facilities. Reports were those by Beigel and Feder (24), Boudewyns and Wilson (51), Boudewyns (52), Caffry et al. (72), Claghorn et al. (86), Deiker and Villemarette (101), Elliott (113), Goldsmith and McGall (154), Gove and Lubach (158), Grimberg and Franzen (164), Heap et al. (176), Lewis (250), Maley et al. (271), Maris and Connor (273), Reichenfeld et al. (349), Remnet (351), Salter and Salter (369), Spence et al. (405), Wiernasz (443).

These 19 reports concerned efforts to change the context of the traditional hospital; all attempted to create a more normal social intercourse within the hospital setting. The inactivity, boredom, and depersonalization found in the traditional hospital setting were counteracted through scheduled activities, challenging verbal interaction in groups, or practice of "activities of daily living" under a token economy.

The descriptions of programs fell rather naturally into two groups. The first group, including 14 reports, discussed development of a new situation on the ward of a hospital. These 14 programs were designed to prepare patients for discharge or to increase the probability of discharge. Grimberg and Franzen (164), Spence et al. (405), and Wiernasz (443) reported conversion of hospital wards from custodial to developmental goals, as suggested by the phrases "simulated money society," "resocialization," and "quarterway house." Beigel and Feder (24) described a "night hospital program" in which a supportive milieu, forms of group treatment, and family participation were combined.

A smaller group of five programs set in hospitals was aimed at increased awareness, functional level, and self-care abilities of long-term patients with little prospect of discharge. Lewis (250), Shapiro (387), and Spence et al. (405) report on programs set in psychogeriatric hospitals. Each of the programs combined group discussion, training, and directed social activities to achieve a better "reality orientation" and higher quality of individual and group life. The program reported by Lewis (250), for example, was establishment of a "social club" by two occupational therapy staff and two students, which was the basis for other "spinoff" activity groups. Another program reported by Elliott (113) was set in a maximum security prison for the criminally insane. Discussion groups and activity groups were used to create a more supportive climate. Remnet (351) reported a project in a convalescent hospital in which a group discussion for 20 to 30 patients, led by staff members and family members, was held for 1½ hours per week. Each week patients reminisced, discussed current events, and discussed the coming week's schedule. From all of these five socialization projects similar benefits were claimed in terms of better relation to current reality, higher morale, and somewhat better self-care.

Program evaluations with sufficient detail to assess outcomes accounted for six of the reports on service innovations in mental hospitals and community hospitals (72, 86, 154, 271, 273, 349). All six evaluations concerned mentally disturbed persons, usually chronic schizophrenic patients. Outcomes of interest were most often appropriate social behavior followed by community tenure and clinical ratings. Treatment programs included drugs, psychotherapy, activities, and token economy, or other training in social skills. Modest positive results were claimed for most of the treatments. Little difference was found in comparison between treatments, e.g., between forms of psychotherapy or between drugs and psychotherapy.

A total of 17 reports discussed service programs set in State training schools or institutions which were neither medically directed hospitals nor community-based residences. Ten of the programs concerned juvenile delinquents. The other seven were aimed at target groups of retarded, aged, or mentally ill persons. Authors of the reports were Allen (8), Baker and Ward (16), Boslow and Manne (50), Brody et al. (59), Brolin (60), Cohen and Hirschfeld (91), Drucker (108), Geiser (144), Ingram et al. (197), Jesness (202), Jesness (203), Kane (211), Levinson et al. (247), Linton (253), Perrow (329), Redfering (348), and Weinstein (437).

Restructuring of residential care and training for juvenile delinquents was apparent in two reports. The Jesness (203) report compared the outcome from application of a transactional analysis

approach at the Close Institution and a behavior modification approach at the Holton Institution, both in California. An attempt was made to measure change in milieu, using the Correctional Institution Environment Scale (CIES). Despite minor differences in perception of the institutions by residents, residents paroled from both programs had lower violation and recidivism rates than a national sample. Also, staff in both institutions saw residents as less aggressive after the program than before. A report by Ingram et al. (197) told of the restructuring of a program for a project group of 20 "psychopathic delinquents" at the National Training School for Boys. Boys in the project were given points for positive behavior and for winning in athletic and other competition. A variety of challenging games and physical activities was offered. Boys committing offenses were put in a "time out" room for 3 minutes, rather than isolated from the group for a longer period of time. Project boys spent fewer days in isolation than others, although rate of assaultive offenses was not significantly different from a nontreatment group. Adjustment of the project boys in the institution was found to be better.

Two other reports stress a humane and commonsense approach to delinquent youth rather than adaptations of clinical techniques. A context which is orderly and humane and which permits the boy to work on his own problems is seen as a sensible and useful approach. Linton (253) describes the "Educateur" professional specialization in France. The Educateur in an institution lives with the children and acts as their model and companion. A somewhat similar situation was presented by Perrow (329) in describing how a new juvenile correctional program in its first few years of existence experimented with intensive "treatment" and also became quite punitive for a while after a riot, but eventually settled for a "humane care" approach.

A third group of program reports, also focusing on delinquents, raised questions about application of the "treatment" label. Boslow and Manne (50) report a multiple-treatment program for "defective delinquents" which featured professional service combined with indeterminate sentence; use of indeterminate sentence was seen as necessary to treatment. A provocative approach to the use of group therapy in treatment at the National Training School is reported by Levinson et al. (247). Noting that the boys strongly resisted attendance at group therapy sessions, the staff tried using assignment to group therapy as a punishment for repeated problem behavior which had led to isolation. Boys assigned to group therapy exhibited improved conduct records after this "punishment."

Research evaluation of new programs, with enough detail to assess outcome, accounts for only four of the reports on innovations in training schools or State institutions. One of the four evaluation projects took place in a State school for the retarded (16), others in

training schools for delinquents (197, 202, 203). Intensive programs of training and activity focused on behavior change appeared promising with two very difficult target groups: psychopathic delinquents (197) and severely retarded school-age children (16). Evaluations of clinically oriented treatment techniques in training schools produced negative or ambiguous results (202, 203).

There were 20 reports of programs of special education and treatment in the classroom. Each program used some combination of educational and personal helping methods. Children needing help were emotionally disturbed or developmentally disabled in some way and usually of grade school age. Reports were by Cantrell and Cantrell (76), Chaffin et al. (81), Connor and Muldoon (95), Frohreich (139), Glavin (149), Glavin et al. (150), Guerin and Szatlocky (165), Halpern (173), Hewett (181), Hewett et al. (182), Hewett et al. (183), Jenkins et al. (200), Marrone and Anderson (275), Mishne (297), Muth and Singell (306), Pimm and McClure (334), Salomone et al. (368), Stabler et al. (407), Walker (432), and Zeeman and Martucci (453).

Many of these reports addressed the question of integration of special education students in regular classrooms. As noted in chapter 2, there is no clear indication that integration is superior to nonintegration, although investigators and teachers generally seem to favor integration.

A report by Guerin and Szatlocky (165) concerned educators' attitudes toward integration. A survey of special education techniques was carried out in several California school districts. Use of learning resource centers, accommodation classes, and other highly integrating techniques were popular with teachers and administrators. Techniques of partial integration of handicapped students were least supported by teachers.

The report by Marrone and Anderson (275) concerned a program for disturbed children which involved parents and sought to reintegrate the students over a period of years. After 4 years, only one-third of the students were reintegrated.

Actual modification in the classroom situation was of three types: integration, resource rooms, and highly programed situations. Integration meant the combining of handicapped and normal children in the same classroom. Muth and Singell (306) reported higher self-concept with partial integration. Resource rooms were used as a method of augmenting regular classes part of the day for selected children. Glavin (149, 150) described the Temple resource room as provision of individually tailored remedial experiences for part of the day for selected children. Evaluations of classroom modifications were reported by several investigators (81, 149, 150, 183). Evidence with respect to both academic achievement and social behavior was mixed, and no clear direction emerged for future work.

Twenty-three research reports and program reports concerned helping activity which was based in a community agency or clinic. The traditional mental health clinic or family service agency, the modern mental health center, or a decentralized "store front" service center are examples of these settings. Reports were by Adams (2), Benney et al. (29), Donlon et al. (107), Flint and Deloach (131), Flomenhaft et al. (132), Flynn (133), Garetz and Peth (141), Golden et al. (153), Herz et al. (180), Jensen and Womach (201), Levis and Carrera (248), Lurie and Ron (267), O'Brien et al. (314), Polakow and Doctor (339), Quick et al. (343), Rada et al. (344), Santostefano and Stayton (374), Schwartz (381), Shin and Kerstetter (392), Smolen and Lifton (403), Talent and Keldagard (418), Whitman and Oppenheimer (441), and Zimberg (455). With striking exceptions, as noted below, these reports were not substantial or original. The low number of items and the lack of substance may be interpreted as professional "benign neglect" of the more handicapped target population needing help. Perhaps persons needing long-term help are apt to be served by semiprofessionals and outreach programs in their own homes or in institutional settings. In any case, there are few innovations to report here.

The 23 reports are not classified because setting and technique varied widely. The one cluster of reports in this section concerns group treatment based in an agency or clinic structure. Eight of the 10 "group technique" programs were programs for the mentally ill.

Aside from the "group technique" items, there were a number of programs aimed at the retarded and the aged target groups. Agency-based programs included intensive training of foster parents (343), the locating of a medical service in a high-rise project for the aged (141), casefinding in mental retardation (441), and outpatient services to reach autistic children (201) or black ghetto residents (455).

Two reports may be noted here as representatives of new approaches in the agency-clinic setting. Flynn (133) recounts the many benefits of use of a team approach to screen old people for placement in foster family arrangements. Of 366 persons referred, about one-half were screened, and of that group 40 percent were placed in foster care. Flynn claims that the team approach led to better planning. Schwartz (381) expounds a special kind of group therapy which he believes particularly helpful for people in transitional or situational stress crisis. The technique is called "Situation/Transition" groups. Five to 12 people meet with a professional leader to discuss their practical problems, express their concerns, and clarify their thinking.

Four well-documented evaluation research reports showed positive results from new programs. A program of aggressive team treatment was successful in keeping psychiatric patients out of the hospital as reported by Flomenhaft et al. (132). Donlon et al. (107)

reported that nonthreatening group psychotherapy was more effective than individual therapy in engaging paranoid schizophrenics in treatment. In two studies of new ways to help drug addicts, success was reported by Polakow and Doctor (339) for a behavior modification program and by Shin and Kerstetter (392) for methadone as part of a multimodal approach. This group of effective programs contrasts with the other reports in use of multiple methods of helping, in aggressive helping, and in severely troubled target groups.

There were 24 reports of *innovative programs located in the general community.* The reports were made by Ash (15), Barresi and Coyle (21), Berg and Hirsch (33), Berleman et al. (38), Berleman and Steinburn (39), Blenkner et al. (46), Fisher et al. (129), Garfield and Kurtz (142), Hogarty et al. (188), Hogarty et al. (189), Hogarty et al. (190), Leonard and Kelly (241), Lundman et al. (266), Marx et al. (277), McManus (284), Miller et al. (292), Munns et al. (305), Nejelski (310), Purvis and Miskimins (342), Rice and Semmelroth (352), Rubington (364), Stein et al. (409), Tobin et al. (419), and Warren (436). These programs delivered counseling, advocacy, or training in whatever setting was most convenient. They were not primarily based in an agency or a residence, nor did the interaction take place in the client's home. Among the programs were those based in a steel company, in a model city project, a family service agency, and State welfare or mental health facilities. These several reports of community-based services are difficult to summarize, but there are certain aspects of organizational structure and location which the programs had in common. Most of the programs began on a demonstration or experimental basis and probably ended after the special funds ended. Second, most of the projects did not create a new physical or organizational structure. Rather, workers were put out into the community to meet people in need at whatever point they expressed their need. Most of the programs attempted to pick up alcoholics or ex-mental patients or delinquents at a difficult transition point and then arrange a sequence of services to achieve more normal functioning.

A report by Berg and Hirsch (33) concerned a multiple model outreach program for minority group aged in an urban area. This project began with a complete canvass of the area and continued with a community organization approach to organize mutual self-help and social activity groups. Fisher et al. (129) told about an aftercare program for ex-mental patients based in a family service agency. The program involved both discharged patients and their families in a succession of services, including help with relocation, group activities, employment, and recreation. Only one quarter of the clients in the program had to be rehospitalized, compared with about two-thirds of previous aftercare groups. The report by

Leonard and Kelly (241) told of a "Geriatric Evaluation Service" to screen mentally impaired older persons for whom hospitalization is being considered. Case study and active efforts to divert persons from hospitalization resulted in a showing that only about one-fourth of the total group of 465 persons subsequently entered the hospital. This program is of interest because, rather than establishing a clinic location and clinic team, emphasis was on a "broker" function. The patient and family were helped to obtain and coordinate community services from other settings. The staff function was to reach out into the community to help the family with its planning and to provide a minimal physical examination and screening function by the project staff. The report by Munns et al. (305) recounts a narcotics prevention project in a Mexican-American area where 30 addicts were employed as social service field workers. The project delivered a complete range of services from detoxification to successful employment. The Rubington report (364) described an alcoholic control unit in a skid row area. Alcoholic men known to the service were employed to remove sleeping drunks to the unit and to see whether some kind of rehabilitation or health service could be provided to them.

Evaluation research of community programs included several well-designed and significant reports. Help to mental patients, juveniles, and others in the community, to avoid institutional placement, came under this heading. Both positive and negative results were reported from substantial studies, but negative results predominated.

Three reports on help to predelinquents can be grouped. Lundman et al. (266) reviewed preventive studies, where social and allied services were offered to avert delinquency, with negative conclusions. Berleman and Steinburn (39), in a similar review, also reached negative conclusions but suggest that service was superficial (one or two contacts per month) and that superficiality might account for negative findings. Berleman, Seaberg, and Steinburn (38) also reported a careful evaluation of a program in Seattle. The Seattle Atlantic Street Center project did offer substantial social work services, but again the results were altogether negative. Hogarty et al. in a series of studies (188, 189, 190) concluded that for maintaining schizophrenics in the community, drugs were helpful, but social work services ("Major Role Therapy") were not. Purvis and Miskimins (342) in an evaluation of aftercare service to discharged mental patients found those receiving more help had greater vocational success, but differences were not significant.

One clue to the failure of professional help in these carefully designed programs may be provided by the Blenkner, Bloom, and Neilsen (46) report. Protective service to older people in the community by qualified social workers was associated with higher

mortality in the experimental group. One explanation offered was that workers encouraged moves to nursing homes to "protect" aged clients, which had the unintended effect of shortening their lives. The clue is that professionals may share a bias toward protection and treatment as being the safer course, when in fact unnecessary help may be injurious.

A second clue to the negative findings throughout these studies may be found in two reports by the same group, Marx, Stein, and Test (277, 409). In one report (277), mental patients were given social and medical services, close attention, a schedule of activities, and appropriate training after discharge from a mental hospital. Patients in the experimental group achieved more autonomy in jobs and living situations than the control group. There was no difference in symptomatology and self-esteem. In the second report (409), young mentally disturbed people were given a similar set of services to divert them from hospitalization. Six of 60 experimental clients were hospitalized as compared with 54 of 60 control patients. The clue to success may be the inclusion of a full schedule of activities and social skills training in these two successful programs. Helping programs were similar in all the projects except for these elements of activities and training. One of the two final evaluations approximated an "absorbing" environment, as defined in the final section of this chapter, and is included there.

Innovations in Context: Old Wine in New Bottles

Certain new situations for helping were emerging and being institutionalized during 1966-1976. The three contexts most often found in this literature survey were local residential facility, daycare center, and home. The numbers of reports concerning each can be seen in this tabulation:

community-based residential facility	23
daycare center	21
home	28

None of these contexts is "new." Local residential facilities were the general rule until specialized State institutions spread across the United States following the 1820s. The idea of home-delivered service is not new either. One need only recall that childbirth and acute illness were attended only at home till the last half-century and that community human services began with "friendly visitors" and "health visitors" 100 years ago. However new or old these contexts, the current shift in policy from large congregate facilities to a flexible range of linked programs is a significant change. It is important to see what shape is taken by these new situations.

There were 22 program descriptions or evaluations of community-based residential facilities. The reports were by Bergman (35), Birenbaum and Seiffer (43), Bram (55), Brook (62), Cannon (75), Fairweather et al. (118), Glasscote et al. (148), Hobbs (185), Kaplan and Ford (212), Luger (265), McNeil (285), Millman and Schaefer (295), Nooe (313), Ozarin and Witkin (323), Pinardi (335), Riehman and O'Brien (355), Rog and Raush (359), Sandall et al. (372), Shean (389), Simmons et al. (398), Vasoli and Fahey (426), and Wilder et al. (444). These small residential facilities have taken many forms: "community homes," "halfway houses," "family residential center," and "lodge," for example. Targeted most often on mental patients, alcoholics, or delinquents, these programs aim to prevent admission to institutions, to ease the transition out of institutions, or in a few cases to help people over a particular crisis in their lives. In addition to these transitional purposes, local residences are being developed for long-term living by such groups as the severely mentally handicapped.

Two national surveys of halfway house programs were reported by Glasscote et al. (148), Cannon (75), and Ozarin and Witkin (323). The surveys showed a rapid and significant increase in halfway house facilities in the United States. There were some 200 halfway houses for mentally ill or mentally ill and alcoholics in the first survey. Houses exclusively for alcoholics were excluded from the first survey. The second survey found some 200 halfway houses primarily for mentally ill and about 600 for alcoholics. Both surveys indicated that halfway houses typically had about 20 beds, but the number of employees per halfway house doubled between the two surveys. Total number of beds also increased from some 3,000 in the first survey to 16,000 in the second survey, with 6,000 for mentally ill and 10,000 for alcoholic persons. These figures should not be treated as more than approximations, since there were a number of nonreturned questionnaires in both surveys. The second survey showed the median number of spaces per house to be 17 or 18. Median cost for houses catering to mentally ill was about $70,000 and for houses catering to alcoholics about $40,000. Cost of operation of mental illness halfway houses was just above $4,000 per bed per year, and cost of operation of alcoholism houses was about $2,400 per bed per year. Most of the houses were under voluntary auspices, and the main sources of income were government purchase of service and fees.

Six programs of service set in small community-based contexts were aimed at the mentally ill (118, 185, 355, 372, 389, 444). The program settings were all similar: There was sponsorship by the State or the hospital staff; there was a residential location accommodating anywhere from 6 to 40 ex-patients; there was an attempt to maximize patients' self-determination; and there was minimal

professional supervision. Fairweather et al. (118) described the development of the "lodge" to facilitate entry of chronic mental patients into community life where they are to take maximum responsibility for themselves, with monitoring by professionals. The lodge program consisted of 15 volunteers from a large group of long-term mental patients who had passed through a training program designed to instill confidence to live in the community. The 15 volunteers, helped and monitored by professionals from the hospital, planned and set up a janitorial gardening service. Hobbs (185) described an approach to readjustment of disturbed children having difficulty in school. Children of normal or better intelligence and conforming behavior were placed in "Re-Ed" where they lived for 5 days, going home on weekends. The Re-Ed program was educational rather than therapeutic; children were to learn to improve relations with family and overcome school problems in a short period of residence. Riehman-O'Brien (355) described a program for groups of ex-mental patients living in apartments in New York City and supervised by a professional team. Group therapy, drugs, and counseling were available, and the intent was for members to find work or other activities and move on to family or independent living. Sandall et al. (372) reported on supervised group living in apartments for ex-mental patients. Shean (389) reported on a number of female ex-mental patients who lived together in a rented house and shared household duties while seeking to become reestablished in the community. The program was distinctive in that a community corporation with a board of local citizens was formed to sponsor this group. The corporation borrowed $10,000 which together with a $10,000 subsidy from the State permitted them to begin operating. Wilder et al. (444) reported on a "high expectation" halfway house program for young ex-mental patients. Residents took responsibility for maintaining the home and were expected to move quickly into employment. Older and more employable residents were more often rated a "success."

A program to prevent, rather than follow up, hospitalization was presented by Brook (62). A "crisis hostel" was established near downtown Denver with space for four patients. Housekeeping and minimal supervision were provided by unpaid volunteers. The facility was really an extension of the mental health center in that staff could place persons in a psychiatric emergency in that house and then provide treatment and supervision as appropriate. Average days of stay were about 6. In several cases it was thought that this facility avoided hospitalization at a cost of only $10 to $15 per space per day.

Three reports, Bergman (35), Birenbaum and Seiffer (43), and Nooe (313), described community residences for retarded persons. All three reports concerned efforts to move long-term retarded

adults out of State institutions to enable them to find jobs and lead more satisfying existences. One of the problems noted was the difficulty of obtaining timely and appropriate service from community health and welfare agencies. Problems of accessibility caused serious delays in one of the facilities. There are indications that these facilities all tended to "cream" the State schools for retarded. It was suggested that cost of care in these community residences was cheaper than in State institutions; this claim may be open to question because there was heavy reliance on State-administered welfare programs and in some cases payment from families, so that true cost was probably not determined. The programs were very similar as to target group, goal, and activities. There were wide differences in formal organization and personnel. The Bergman report (35) indicated that a group of professionals established a pattern for community homes with community-formed corporations and small-sized houses (7-10 residents) with "house parents" to help residents and direct the home. The Birenbaum-Seiffer report (43) described the formation of Gatewood as a model for moving retarded adults back to New York City. Gatewood accommodated almost 50 men and women. The pattern of self-governance was responsibility vested in paid managers but with a good deal of resident participation and decisionmaking. The Nooe report (313) described a program where a transitional residence for eight retarded persons was governed by a staff of part-time mental health professionals. In this residence there were more professional treatment and less emphasis on work and self-governance than in the other two community residences just described.

McNeil (285) and Vasoli and Fahey (426) described halfway house programs for delinquents. A temporary residence for adjudicated delinquents in Flint, Michigan, was described by McNeil. The house was operated by non-live-in professionals who emphasized personalized treatment with individual goals. The Youth Center described by Vasoli was based in a hotel in Gary and took youths from the State reformatory to help them find jobs and reenter the community. There was an employment agreement with the Inland Steel Company. Recreation supervision, counseling, and other services were obtained from community agencies. The program served 77 youths in its first year.

A program to prevent family breakup in abuse cases was described by Simmons et al. (398). A Family Residential Center was based in two public housing apartments. Abused children lived in these apartments with houseparents, but the children's own parents were given almost unlimited visiting privileges and expected to help with management of their children.

Evaluation research on community-based residential settings was thin indeed. Rog and Raush (359) surveyed 26 studies of halfway

houses. They estimated that, on followup, one-fifth of the total residents were rehospitalized and over half were attending school or holding jobs. The results were considered encouraging. The only two evaluations with sufficient information to assess the results were the volume on Gatewood by Birenbaum and Seiffer (43) and the volume on the lodge by Fairweather (118). Both these experiments were considered successful in that most residents stayed in the community. Residents moved toward employment and self-reliance more than did comparison groups. These two projects are discussed further as "absorbing situations" in the last part of chapter 1.

The *daycare center* or workshop is another distinctive type of context in which help is increasingly being offered. Twenty relevant reports were found, written by Cohen (88), Glaser (147), Gustafson (168), Hewett (181), Hicks and Wieder (184), Kliebhan (223), Koff (226), Kostick (227), McDonald et al. (280), Nathanson and Reingold (307), O'Connor (315), Petrov and Vlahlyska (331), Post et al. (340), Pumphrey et al. (341), Rathbone-McCuan and Levinson (347), Shapiro (387), Strickland and Arrell (414), Turbow (423), Villeponteaux (427), and Wolkson and Tanaka (447). Most of the reports were program descriptions rather than research reports and were sketchy. Almost no systematic research was found on day programs.

The central idea of these day programs was to maximize family or community living for handicapped people, while also providing protection, social development, or corrective programs. A frequent theme was that institutionalization was avoided and that the cost of daycare, around $10 to $15 per day, was much less than institutional care, but one cannot make generalizations about organization structure or cost, since the program descriptions were incomplete.

Glaser (147) in describing Our Place, a day hospital program at Temple University, began with a philosophy for day treatment. Main themes were deep involvement of staff in both hospital and homes, therapeutic community (i.e., intimate and mutually responsible groups of staff and patients), multiple uses of group therapy with no individual therapy, and avoidance of physician direction with its overtones of authority. McDonald et al. (280) described a geriatric daycare center staffed by an interdisciplinary mental health team for development of social skills among psychotic elderly persons living in the community. Cost was just over $10 per day.

Three of the reports address the question whether daycare or day treatment is better offered in conjunction with a medically directed hospital or in a free-standing organization. Gustafson (168) in a description of two day-treatment programs in Hawaii indicates that administrative and daycare staff cannot serve both the medical facility and the community-oriented daycare center. She recommends dispersed, smaller community-based centers without the

medical or institutional overtones. Koff (226) indicates that a large daycare program in a nursing home offered care at two sites; the one in the nursing home was health oriented, while the other was primarily recreational. There was general satisfaction with this arrangement because patients could select the program meeting their desires. Kostick (227) outlined development of a daycare program for elderly physically or emotionally handicapped people. Initially the daycare patients were assigned to the staff on one or another services of the hospital. Neither staff nor residents accepted the daycare participants. After the daycare staff was moved to a separate section of the institution, the staff and patients formed a more positive relationship as a group, and the program was more successful. The daycare center was seen as serving a "broker" purpose in obtaining specialized services for participants. Cost of this program was about $11 per day, a level mentioned in several of the reports.

A group of four reports illustrate daycare programs which are focused on activities and not "treatment." Nathanson and Reingold (307) describe establishment of a successful workshop where elderly residents of a Hebrew home for the aged, most with chronic brain syndrome, were given the opportunity to work and earn small amounts of money. The goal of the workshop was social activity and satisfaction for the residents. A Creative Living Center described by O'Connor (315) was an experiment in a completely activity-oriented program of daycare for mentally ill persons in the community. Conventional forms of treatment, such as drugs, psychotherapy, and group therapy, were not provided. Activities themselves, it was believed, were instrumental in keeping ex-patients in the community. Petrov and Vlahlyska (331) described cultural therapy for older handicapped people in Sofia, Bulgaria. Different activities, such as history study, political lectures, and singing, were organized for older people. Still other examples were socialization therapy at the Levindale daycare center as described by Rathbone et al. (347) and music therapy at the Montefiore Home for the Aged, reported by Shapiro (387).

There were no evaluation research reports on daycare situations in sufficient substance to permit an assessment of their significance.

Home-based help was the topic of 24 reports of research or program innovations. It may seem odd that the home and family setting should be considered a new context for helping. The professionalization of social helping and personal care, however, progressed so far by the mid-20th century that with a few exceptions most human services were delivered in offices, clinics, or institutions. Authors of reports on home helping included Alexander and Parsons (7), Angrist and Dinitz (10), Arthur et al. (14), Bell (26), Berg et al. (34), Blenkner (45), Brody (58), Bronson (61), Buckey et al. (65), Cohen

and Ewalt (89), Cohen (90), Davis et al. (100), Egan and Robinson (112), Flomenhaft et al. (132), Hicks and Wieder (184), Jones et al. (204), Klason (210), Keener (215), Latham and Hofmeister (234), Nielsen et al. (312), Safier (367), Santostefano and Stayton (374), Silberstein et al. (396), and Waldman et al. (431).

An appreciation of the vital positive effect of home setting and personal supports ran through many of the 24 reports. Delivery of services to the home was more than a means of saving money by keeping people out of institutions and was more than a thrust to reach new populations. Professional helpers, rather, were often seeking to amplify their own effectiveness by working with existing strengths or by modifying the family social interactions toward more positive effects. These themes are emphasized in the following review.

The programs of home helping can be divided among those with developmental goals and those with maintenance goals. "Developmental" goals are change in family relations and reduction of delinquent behavior through family reinforcement of positive behaviors. Jones, Neumann, and Shyne (204) evaluated a program to help children in disturbed families and prevent foster placement. Help included social, health, advocacy, recreation, and other services as needed. Cost of home service was one-fifth that of foster placement. Percent of children placed and days in placement was lower than in an experimental group. This project was similar to the successful program to prevent psychiatric hospitalization reported by Flomenhaft et al. (132). The Flomenhaft et al. project was summarized above as a clinic-based project, but it is significant that the clinical team made one home visit within 24 hours of the application for help and also interviewed key family members and friends.

An approach which focuses on developing new family interactions was illustrated by the Alexander and Parsons report (7). Parents of juvenile delinquent children were helped to change their situation through assessment of problem behaviors and contingency contracting.

A home-care program for severely disturbed children, described by Cohen and Ewalt (89), was supplemented by task-centered family therapy to help the parents solve problems in daily care and training of their retarded child. Hicks and Wieder (184) reported that young adults suffering from cerebral palsy enrolled in a sheltered workshop program were engaged in group therapy along with their parents to solve family relationship problems. Other reports (234, 374) describe programs to help parents develop new ways to teach or interact with children.

The maintenance of aged impaired or chronically mentally disturbed persons at home was the purpose displayed in a larger group of research and program reports. To lead into this topic, two re-

views of relevant research should be noted. Angrist, Dinitz, and Simon (10) reviewed the research on home care for psychiatric disorders and concluded that home care is of proven effectiveness. What remains is to specify conditions for success and focus on costs and burdens on families. These authors emphasize that a combination of vocational, social, and health programs is needed along with access to inpatient care and other services. The importance of multimodal services is supported by many research reports covered in this review.

A review of research on relocation of older people by Blenkner (45) indicated that placement away from home increases mortality. Ironically, placement of older people as a means of "helping" them may shorten their lives. Brody (58) described a program of intermediate housing designed to avoid placement in institutions or nursing homes. Provision of an emergency-call service, social facilities, and maintenance on a communal basis led to greater satisfaction than that exhibited by a comparison group. A Jewish family service agency in Philadelphia, as described by Cohen (90), adopted an outreach/advocacy approach to help older people remain in their own homes. A community survey identified needs. A wide variety of practical social and socializing services was offered on an "as requested" basis. The staff believed that social clubs, a drop-in coffee lounge, and a home-visiting/home-help program were extremely useful in combating loneliness and maintaining independent living. A report by Bronson (61) described an experiment in which older people living alone with nonsevere handicaps were combined into groups which rented apartments from the project. The project provided several social and housekeeping services to permit maintenance of independence.

A home-aide service for middle and upper income aged after discharge from a geriatric hospital was described by Nielsen et al. (312). The help given seemed to increase contentment and to reduce hospital and nursing home admissions, unlike a comparison group. An unexpected finding was the readiness of family members to step forward and help maintain independence. A similar program of help for a different target group is described by Berg et al. (34). For about $100 per month, individual "packages" of homemaking and other services were delivered to aged poor in Milwaukee. Other programs of home helping to maintain independent living were also found (90, 210, 367).

A specialized health service—namely, physical examinations and recommendations—was delivered to older people in two program experiments as described by Bell (26) and Waldman et al. (431). In a southern State, free examinations were delivered to rural residents by a mobile team. The cost was about $20 per person, and almost 3,000 elderly were screened in the first 6 months. Two-thirds of

persons seen were white, though blacks exhibited more serious problems. The report by Waldman et al. (431) also involved free physical examinations and medical treatment, but this time through an outpost located in an elderly housing project. A comparison with matched controls not being examined indicated that the exams and recommendations for service did not lead to lower mortality. In neither project was there followup to see whether recommended health attention was actually obtained.

Absorbing Situations: New Wine in New Bottles

Research evaluation of completely new contexts for help was found in a small number of reports in this review. Provocative notions about helping were suggested by that small number of research reports where new ways of helping were combined with specifically designed helping situations: "new wine in new bottles."

The term "absorbing situations" has been coined to summarize the most interesting features of these novel helping situations. Practice experiments where effective help was delivered to very needy and handicapped populations were characterized by an environment that was at once highly structured and demanding but also supportive. The person being helped, for a period from 4 months to several years, lived within a regime of activity where classes, duties, recreational activities, and social interaction were all directed toward specified goals. These situations were all truly "absorbing."

From the several dozen reports particularly relevant for this literature search on new contexts for help, a small group of 10 has been selected to represent deliberate creation of new absorbing contexts. Each of these 10 reports dealt with a novel and closely reasoned program carried out in a deliberately designed context for a severely handicapped population. Outcomes were systematically observed. The program of help in each case was of sufficient scope and substance so that one might expect some impact. Ten research reports which met these criteria are reviewed below.

Four reports concerned the creation of special places, each designed for a specific purpose. Gatewood, as described by Birenbaum and Seiffer (43), was a place in New York City where about 60 retarded adults from traditional State training schools of New York were sent to live. The mean IQ of these residents was 51, mean age was 33, and mean years in State school residence was 18. Gatewood was a place created to permit "normalization" of these retarded adults. Residents were reinserted into the community. Followup interviews indicated significant gains in community participation, social relations, and self-reliance. Two features of this experience were of special significance: the manner in which a

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pattern of institutionalization was imposed on a new group of attendants by the mentally retarded residents, during the first 6 months of the project; and the many difficulties in the program arising from failure to obtain needed supportive services from other agencies and institutions in New York City.

The lodge, as described by Fairweather (118), was the prototype program for an intermediate living situation, largely self-directed, for mental patients leaving traditional State hospitals. A closely planned series of stages was used to prepare chronic mental patients to leave the hospital. Fairweather describes the experience of 15 volunteer patients who left the hospital to set up the first lodge or community work-living situation. This absorbing situation was characterized as in other cases by close attention to all daily activities: planning of chores, recreational activities, employment, and conduct of joint business. The pioneer lodge group set up a janitorial-gardening service as a source of income. Professional staff from the hospital were available for advice and monitoring. Lodge group members, compared with control group members over a period of years, stayed out of the hospital longer, spent more time in full-time employment, and were more satisfied with community living.

Four years' experience with Southfields, a Kentucky replication of the New Jersey Highfields program for delinquents, was reported by Miller (293). The context created at Southfields was based on the principle of exhibiting values of a dominant culture. Values were exhibited and reinforced through supervision of activities, structured discussion groups, and a fully planned schedule. Control group design did not seem feasible, but comparison of recidivism with boys assigned to correctional institutions and to the Highfields program indicated that the program was effective.

A large, old, frame house in San Francisco became Soteria, a place for providing help and resocialization to mentally disturbed adults. The experiment was described by Mosher, Menn, and Matthews (302). Six young first-time schizophrenic patients at a time lived in Soteria with six paid staff members. The method of helping was for the young staff members to live with and talk with those needing help, to help them work out problems in relating to their families and in directing their own lives. Traditional psychotherapy was not used, and use of drugs was limited. Close attention was given to the problems of daily living, including chores, recreation, and conduct of personal relations. As compared with young control patients not assigned to Soteria, Soteria residents showed more normal role performance in employment, school attendance, and in sexual relations. The young experimental subjects also showed less psychopathology and fewer hospital readmissions than the other group. Average cost of Soteria for each resident ($4,400)

was almost exactly the same as average cost of hospitalization for control subjects.

Three of the 10 reports dealt with children, specifically, with severely retarded or severely disturbed grade school-age children in residential settings. In each case, the experiment took place in a traditional residential institution, but a completely new context for helping was created in one ward or one classroom of the institution.

Baker and Ward (16) described a program for closely supervised training of severely retarded children, using "total reinforcement" principles. Six children in a State school for retarded were placed on an experimental ward with five specially trained attendants who carried out training through reinforcement techniques and also observed and recorded problem behaviors. Reduction of problem behaviors and standard tests of development both showed more gains among the experimental children than among a control group on a regular ward. Balthazar, English, and Sindberg (20) described a similar program of "nurturant nursing" for severely retarded children in a 24-hour-a-day supportive milieu which was made as homelike as possible. After 4 months of treatment, the experimental children from an original group of 16 showed more gains in appropriate social behaviors than the control children. Bartak and Rutter (22) described the outcome of a highly structured teaching program for autistic children in an English institution. Results of a well-controlled classroom situation with emphasis on specific teaching and high staff-children ratio, operated on reinforcement principles, were compared with less structured play-group or classroom situations operated on emotionally supportive or regressive principles. The well-controlled classroom showed significant advantages in scholastic progress.

In short, the three experiments for severely retarded or disturbed children each showed positive results from closely supervised and well-structured contexts where emphasis was on training in specific capabilities.

A final group of three programs had in common the establishment of an "absorbing situation" in the open community. All three studies were targeted on mental patients. All three exhibited an emphasis on activities of daily living and training as well as on treatment, and all three were successful.

Chien and Cole (83) described a project to support ex-mental patients in the community through a cooperative apartment program. One hundred and eighty-six patients, mostly chronic schizophrenics, were placed in 35 cooperative apartments upon leaving Boston State Hospital. Local landlords were recruited and trained to act as supervisors of ex-patients. A professional team from the hospital supplied support and backup service. This project was

different from several other apartment living projects in that there was a substantial investment of professional resources. The justification for calling this an "absorbing" context is that the professional team visited each apartment at least once a week. Further, there was close attention to the daily routine of homemaking chores, community activities, etc. Each patient either held a job or attended the hospital daycare center. Over a period of several years, it was possible to maintain over 80 percent of these homeless ex-patients in the community, at a cost of about $2,200 per patient per year. Marx,Test, and Stein (277) tell of an experiment with State hospital patients who were evaluated as "not capable of sustained community living." The patients were randomly divided between a community-based living group and two hospital control groups. The community treatment group were fully scheduled and closely followed by hospital staff. A special feature of this experiment was that one in-hospital control group was also given similar supervision under the cover of "preparation" for discharge. The community treatment group exhibited more autonomy in living situations and in employment than either of the other two groups after 5 months. A second report by the same group of investigators (Stein, Test, and Marx, 409) described establishment of a controlled living situation for young severely disturbed applicants to a State hospital. In order to divert these applicants from hospitalization, the staff arranged a full schedule of daily activities, recreation, and training in social skills. Most of a control group of 60 patients were hospitalized, but only one-tenth of the experimental group was hospitalized. On a 4-month followup, the experimental patients exhibited more independent living and less unemployment, while there was no difference in symptomatology, social relations, or attitudes.

CHAPTER 2

FACTORS IN EFFECTIVE HELPING

Three leading issues of the past two decades, in relation to helping services, were illuminated by evaluation and research reports of 1966-1976. The issue of standard therapy techniques and goals was one around which much evaluation research clustered. Are standard psychotherapy methods and qualified professional helpers necessary to make a service effective? Should standard techniques of therapy and personality change be more widely diffused? How important are situational factors? Are helpers who are not qualified in standard techniques apt to do more harm than good? Thirty evaluation research reports, and a larger number of essays and program reports, throw new light on these questions.

The issue of treatment and care as a self-perpetuating activity, where change goals are displaced by maintenance goals, is a second issue of interest. Freud's essay on treatment, "terminable and interminable," was perhaps the first thoughtful consideration of whether treatment activity became an end in itself. In the 1960s, with growing conviction that traditional institutions were not helpful, there was growing concern over factors correlated with length of care or treatment. A number of research reports in the last decade bore on that issue.

The issue of placement of those in need of help in special settings with others like themselves is another important one for discussion. Is it unfair to handicapped or disturbed persons to be mixed with "normal" persons? Or is it better, in fact, for the rehabilitation and development of those labeled as needing help to interact with persons not so labeled? This question applies to retarded children, the impaired aged, emotionally disturbed adults, and many other groups. This issue, though, was systematically studied only in relation to integration of children with learning problems in the school situation. Research bearing on the issue of segregation of those needing help in the school setting is reviewed in the last part of this chapter.

Evaluation of Standard Therapy Techniques

For at least a century, the need to professionalize helping has been an article of faith among the enlightened. The professionalization of helping involves advanced professional training, treatment goals of lasting personality change, and skill in use of codified treatments. The treatment methods often involve verbal interaction, group influence, or chemical effects but may also include interventions. The treatment methods are based upon a body of theory and a lore of application as a subpart of professional knowledge.

Practical, nonprofessional helping has, of necessity, continued. Professionals are too costly, too few, and too selective to be employed exclusively to deal with the hundreds of thousands of those needing help. Training for nonprofessional helpers includes provision of advice, skill practice, and practical, direct help aimed at immediate concerns. The goal of such helping is apt to be current satisfactory performance rather than lasting personality change. Professionals in the human services and enlightened lay people tend to view such help as, at best, only a palliative treatment of symptoms, or, at worst, dangerous.

In this review there were about two dozen reports of substantial evaluation research on standard therapy techniques. A like number of reports were found where practical help, or help from relatives or volunteers, was evaluated. The comparison of outcomes, as claimed by authors of the reports, was unfavorable to standard therapy methods. Details are given below.

In this survey there were 20 evaluation reports where standard treatments were the focus of attention; the reports were those of Adams (3), Allerhand et al. (9), Berleman et al. (38), Blenkner et al. (46), Caffry et al. (72), Claghorn et al. (86), Davis et al. (100), Donlon et al. (107), Herz et al. (180), Hogarty et al. (188), Hogarty et al. (189), Hogarty et al. (190), Jesness (202), Jesness (203), Jones et al. (204), Klein (224), Lerman (243), Palmer (325), Shin and Kerstetter (392), and Truax et al. (422). New contexts were not created. The reports concerned, with very few exceptions, provision of services to long-term-care populations. Qualified professionals were employed to give treatment. The results from this group of studies of standard treatment modalities can be summarized quite simply. Treatments tested included drug therapy, group and individual psychotherapy, street work, social casework, and special variations on group or individual clinical programs. Only one treatment modality, drug therapy for the management of schizophrenics outside the hospital, figured more often in positive results than negative results.

In only eight reports were there convincing claims of positive results. There were several cases where early positive findings were contradicted by later work (3, 188, 202, 325). There were several reports on reductions in problem behavior while under care or of improved cooperation with medical or social service (107, 202, 325). In the present review these are not given much weight, since they represent conformity with professional or administrative requirements, not improvement of handicap or reduction of care. The only positive findings remaining were a multimodal treatment program for schizophrenics which reduced pathology and also reduced readmission (72); a multimodal (drugs, medical, social service) program for drug addicts which reduced arrests (392); and group psychotherapy for juvenile females under care which was reported to enhance their self-esteem (422). Positive results from standard treatment were definitely outweighed by negative results.

The 20 evaluation research reports will be grouped by target population for review. Nine of the reports concerned mentally ill persons, usually schizophrenic ex-mental patients receiving some combination of drugs, social service, positive milieu, and group or individual therapy in the community (9, 72, 86, 100, 107, 180, 188, 189, 190). Most reports gave negative findings or findings of no significant difference between kinds of treatment. The only positive findings were for drugs, and even here the evidence was equivocal. Hogarty and associates (188, 189, 190) claimed in an early report an additive effect of drugs with Major Role Therapy (MRT). In the third of the three reports, which was a followup of schizophrenic patients using relapse as a criterion, it was reported that there was a main effect from drugs but not from MRT. These studies, then, indicated that drugs were important in maintaining schizophrenic patients in the community.

The well-known Louisville study on drug and social service maintenance by Pasamanick and associates was followed up by Davis et al. (100) with negative results. No difference was found between home-care groups in the earlier study and the control groups remaining in the hospital. Criteria included rehospitalization, clinical rating, and social problem reports. A study by Claghorn et al. (86) found that when schizophrenics were assigned to four treatment groups with combinations of two different drugs and psychotherapy or no psychotherapy, there were no significant differences in clinical ratings among the groups. This finding would support the finding reported by Hogarty and associates that drugs but not psychotherapy were effective. The Claghorn group did not indicate whether experience with use of drugs alone was different from other treatment regimes. Another report with positive results by Caffry et al. (72) claimed reduction of pathology and also less rehospitalization resulting from a comprehensive aftercare treatment

program for schizophrenics in acute episodes consisting of drugs, psychotherapy, and social services. Positive findings were also reported by Donlon et al. (107) from a project where "refractory" schizophrenics were treated in a highly supportive milieu. Investigators found improvements in attendance and socialization. A study of aftercare treatment by Herz et al. (180) compared individual and group treatments and found no difference. The treatment in this experiment required only 1½ hours per week of the time of each of several psychiatric residents, divided among an average of 12 patients. A followup of disturbed children at Bellefaire, a residential treatment institution, by Allerhand et al. (9) did not support efficacy of treatment. The role performance of children at discharge was best predicted by role performance at admission, not by treatment or personal factors. The supportiveness of the child's living situation after discharge was an effective intervening variable in predicting postdischarge role performance; again, treatment variables were not significant.

Eight reports involved delinquents (3, 38, 202, 203, 224, 243, 325, 422). Two of these reports, by Jesness (202) and Palmer (325), concerned the "I-Level" diagnostic scheme and the community treatment program developed in California. Both reports claimed similar positive outcomes in problem behavior. Negative results were reported by Jesness for parole violation and by Palmer for postdischarge records. These positive reports are questionable in light of Lerman's reinterpretation of the California experiments (243). Lerman rejected claims of positive findings after applying additional criteria. Two other delinquency experiments from California were reported by Adams (3) and Klein (224). Reduction in recorded offenses among certain Los Angeles gangs was attributed to a streetworker program combining planned activities and personal social services. Klein later reported an increase in number of recorded offenses, rather than a decrease. Klein speculated that services offered through the gang had the unintended effect of strengthening cohesiveness of the gang, which in turn contributed to increase of recorded offenses. Jesness (203) compared the impact of transactional analysis and behavioral modification programs on "institutional social climate" in two California institutions. Staff of both institutions were found to be more favorable about both programs than residents. The transactional analysis program seemed to produce more positive results than the behavior modification program. The most significant finding, however, might have been that youth paroled from each of these programs had significantly lower parole violations and recidivism records than youths discharged from other California institutions. This reviewer would interpret the experiment as showing that high and explicit per-

formance expectations combined with a supportive structure can produce favorable results. A followup study of group psychotherapy with delinquent girls by Truax et al. (422) found that two group meetings per week for 3 months had positive effects on self-concept and problem behavior of institutionalized delinquent females. Design and outcome measures were carefully worked out. The final delinquency experiment also concerned individualized programs of treatment but had negative outcome. The Seattle project reported by Berlemen, Seaberg, and Steinburn (38) was directed at boys identified as problems through school or police reports. Services included group treatment and casework as well as community advocacy by three social workers for 52 boys and their families in the community. The results were the reverse of those expected; boys in the experimental group demonstrated more problem behavior than boys in the control group.

Of the three remaining reports in this section (46, 204, 392), one concerned vulnerable aged, one concerned vulnerable children, and one concerned drug abusers. The treatment for vulnerable aged as reported by Blenkner et al. (46) was very similar to that used in the Seattle project. Adequate individualized social work service was provided in home and community for a substantial period of time. Findings were negative, and mortality was greater among aged persons receiving protective services. It was speculated that attention by social workers led to residential changes toward more secure situations and relocation led to a higher mortality rate. The only difference favoring the experimental group was a reduction in "collateral stress," or adverse effects on significant others. A report by Jones et al. (204) concerned dependent children in disorganized families. Community-based delivery of comprehensive social work services was designed to avoid child placement into foster care. Endangered children whose families received service less often were placed in foster care. Children in family foster care at the beginning of the experiment, whose natural families were served, were more often returned home. The final and 19th report in this group by Shin et al. (392) evaluated a multiple impact service project of methadone, peer group therapy, medical services, and supportive social service. Records of self-reported offenses by over 1,000 persons in this program indicated that there was a reduction of arrests after participation in the program.

Nine relevant but less rigorous evaluation studies have not been specifically cited because the design, outcome measure, and details of treatment were not fully reported. Overall, these studies present the same negative or mixed results as the 19 cited above. About one-third presented mixed or weak positive findings, and several

reported negative findings. Only one study claimed a reduction in readmission to care, but there was not enough information to fully assess this claim.

Conventional modes of treatment made a very poor showing among the studies covered by this review. Psychotherapy, social casework, newer modes of clinical treatment, and drug treatment showed mixed or negative results. The poor showing of usual clinical modes of treatment raises the question as to whether the negative results arise from the clinical setting and partializing approach of most therapies. Would psychotherapy or casework be more effective if delivered in a family or community setting, along with medical care and practical aid? To investigate this question, all 28 reports were reexamined. Nine reports were identified in which a "mix" of human services was offered in a community context.

Among the nine reports, five particularly well-designed and carefully reported studies in which some combination of social, educational, and medical services delivered in the community to a good-sized vulnerable population had clear-cut negative results (38, 46, 100, 190, 224). These five projects dealt with three different target groups and were scattered across the country. Each had similar community care programs operating over a period of time; three were followup studies, and the other two projects lasted about 3 years. The outcome criteria—rate of official offenses, mortality, or readmission for mental patients—were meaningful. The treatment program in each case was substantial and sustained and could therefore be expected to produce a result. Results were either "no significant difference" or differences in the wrong direction. Positive results were reported in four studies (72, 204, 392, 422). Three of the studies were multimodal programs of social and health service in the community, and the other program was group psychotherapy in a training school for girls. Positive results were clear and convincing in each case. One notable feature distinguishes these three from the group of five studies with negative findings. The four studies showing positive results dealt with persons at a "crisis" point in their career as handicapped persons, viz., families threatened by official action; schizophrenics at admission to a community facility; known drug abusers referred after a series of offenses; and female delinquents near discharge from an institution. No firm conclusions are justified; yet this reexamination of selected reports does suggest that brief treatment for a crisis situation is more likely to be efficacious than long-term treatment related to general functioning.

Evaluation of Practical Help and Training in Everyday Skills

Seventeen reports contained evaluation studies of training in self-care, development of interpersonal skills, or the provision of practical services, rather than clinical treatment: Benney et al. (29), Brolin (60), Bullington et al. (67), Chaffin et al. (81), Evje et al. (116), Goldsmith and McGall (154), Guthrie and Gasdick (169), Heap et al. (176), Ingram et al. (197), Maley et al. (271), Muth and Singell (306), Nielsen et al. (312), Polakow and Doctor (339), Purvis and Miskimins (342), Reichenfeld et al. (349), Salter and Salter (369), and Turbow (423). These 17 studies contrast with the previous group of experiments in that more practical and more varied services were offered, usually in the community or in the home. Techniques used tended to be direct practical help, advice and information, or training. Target groups for these practical services were generally the most severely handicapped. Outcome criteria were specific conforming behaviors, or specific skill performance, not clinical status. In four of the 11 studies abstracted, the outcome criterion was reduction of care, i.e., earlier discharge or less readmission. In four other cases, improved use of service was the main criterion. Positive results are claimed in all of these reports. Although the quality of research on which these reports are based cannot be adequately assessed, the contrast with the negative results in the previous section is striking.

These studies of practical service and training suggest strongly that a context for care can be designed to elicit specific behaviors, including greater self-care, physical activity, and social or vocational skills. Improvement in specific role behaviors or social development, rather than reduction in symptoms or better adjustment, was generally the goal in these programs. Of the 17 reports, over half concerned mental patients, three were evaluations of programs for mentally retarded, while two concerned drug abusing, one delinquent, and two physically handicapped target groups.

About half the service programs involved training in interpersonal or social skills, or in activities of daily living. Several other programs centered on vocational education. Other studies represented a variety of approaches: employment of ex-addicts as social service workers (67), home helps for aged handicapped just released from hospital (312), and an intrusive activities program for psychogeriatric patients (349). These practical services were aimed at the most immediate and practical deficits in the behavior repertoires of handicapped persons. Desired role behaviors—conversational skill, attendance at meetings, grooming of self, verbal disagreement without violence—were encouraged by social or other reinforcement, by modeling, or in one study by payment of a salary.

A few of these studies are representative examples. In the Goldsmith and McGall study (154), 36 male psychiatric inpatients nearing discharge were assigned to three groups, one of which was an interpersonal skill training group, and the other two of which were control groups. Training in three sessions of the experimental group included initiation and termination of conversation, dealing with rejection, being more assertive, and the like. Behavior rehearsal, modeling, coaching, and recorded playback were used. Both behavioral and self-report measures showed significant difference between experimental and control groups, and after 8 months, more of the controls than experimentals had been readmitted. A report by Reichenfeld et al. (349) assesses a group-oriented activity program in a Canadian psychogeriatric hospital. On each of several comparable wards having 10 or 12 patients each, a nurse led discussion on current topics and encouraged conversation as well as personal reminiscences among group members. Other nurses led such activities as physical exercise, religious services, art therapy, and scheduled recreation. Behavioral observation, standardized rating scales, self-care, and discharge rates all indicated that patients on the wards with the activities program were more active, healthy, and self-sufficient.

Vocational training experiments were aimed largely at mental patients and retarded groups, with positive results reported. In an unusual experiment reported by Bullington et al. (67), habituated drug users were offered service jobs to determine whether regular income would lead to adoption of middle class values. Ex-addicts did learn new social skills, increased their self-esteem, and raised their standard of living. Most planned to stay in social service work.

The exploitation of family ties or of altruism by strangers for providing help under social auspices is another kind of nonprofessional helping. A group of 10 reports focused upon family or volunteer energies: Abbott and Sabatino (1), Alexander and Parsons (7), Arthur et al. (14), Buckey et al. (65), Flomenhaft et al. (132), Holt (194), Kelly and Baer (217), Latham and Hofmeister (234), Rouse and Farb (362), and Santostefano and Stayton (374).

Three of these 10 reports were outstanding in research design, reporting, and relevance. All three documented positive results from engaging family or other interested persons in a formal helping network. The Alexander and Parsons report (7) tells of a project where families of delinquents were taught by discussion and contingency contracting to avoid destructive interactions. Results for family interaction and recidivism were positive. The Arthur et al. report (14) described improvements of morale among aged persons under care, from visits by college students. The Flomenhaft, Kaplan, and Langsley report (132) concerns a completely family-oriented approach to handling of psychiatric episodes so as to

forestall hospitalization. Hospitalization was prevented in 150 experimental cases, and followup data showed subsequent hospitalization to be less as well.

The positive claims for programs of training, social development, and practical help encouraged further exploration of such programs. A number of reports did not include evaluation research but did provide additional insights. Reports were those by Ash (15), Beigel and Feder (24), Bergman (35), Cohen (88), Fisher et al. (129), Geiser (144), Goldberg (151), Grimberg and Franzen (164), Kane (211), Kent and Hirsch (220), Kleibhan (223), Linton (253), Luger (265), McNeil (285), Nathanson and Reingold (307), Nooe (313), O'Connor (315), Perrow (329), Petrov and Vlahlyska (331), Pinardi (335), Rada et al. (344), Rathbone-McCuan and Levinson (347), Remnet (351), Rubington (364), Shapiro (387), Spence et al. (405), Talent and Keldagard (418), Wiernasz (443), and Zimberg (455).

These reports on practical help and training exhibited a refreshing, imaginative connection of services to everyday problems of living among the groups that need help. Reports of social development and practical services exhibited three common characteristics. First, they dealt with the most difficult target groups, often said to be underserved by mental health services: aged and marginally functioning persons, adolescents with serious behavior disturbance, mentally disturbed children, seriously retarded persons, long-term institutional patients diagnosed as schizophrenics, and persons suffering from alcoholism. These groups historically have been considered inaccessible to psychotherapy and have filled back wards of State institutions.

A second characteristic in common was the emphasis on practical rather than professional treatment. There is not yet a lexicon or a theory to clarify this distinction. Perrow uses the term "humane care" to make the distinction. A more common usage is to speak of "socialization treatment" or "resocialization treatment." The difference in any case is clear. Professional treatment in mental health is modeled after the doctor-patient relationship. The doctor is dominant in making decisions, has access to more information, and has control over any significant life changes of the patient. Practical services, on the other hand, are aimed at problems and skills clearly understood by both therapist and patient. Even the method of helping may be subject to negotiation. Signposts for progress are clear and understood by all parties.

A third common characteristics was the tendency toward deprofessionalization among these services. Socialization treatment or practical services was often performed by aides, nurses, members of the target group who were specially trained, or other nonprofessional persons. A family-like situation was created by many of these programs. In instances where comprehensive social development

or practical problem solving was a goal, where the socialization of the client had been impaired, and where the client's family could not provide parenting, the social care situation often recreated the parenting, protecting, and guiding functions of a family. The French "Educateur" program was the clearest case. Many other programs used combinations of acceptance, guidance, mild disapproval, concern with all areas of functioning, and comprehensive support which characterize constructive family life. A few of the reports will be used as an example to illustrate these themes.

Of the 29 reports, almost two-thirds concern social development, and four reports are of programs whose aim was no less then comprehensive social development. Linton (253) described the Educateur professional specialization in France. The Educateur is trained broadly in child development and also in physical and other activity program leadership. The Educateur in an institution lives with the children and acts as their model and companion. Educateurs work in a variety of settings, not only institutions. Linton sees the main benefit as integration of all specialized children's services around the needs of a particular child. Fisher et al. (129) describe an aftercare program in a family service agency. Four stages of socialization of discharged mental patients were described and provided for in the program. The first stage was help in housing, public aid, and access to other services for becoming established in a living situation in the community. The second stage is activity, recreation, other social clubs, and the beginning of training. The third stage is the development of skills to work and live independently. The fourth stage is termination and independent living in the community.

A third report of comprehensive social development was that of Bergman (35) about development of community homes for the retarded in the Boston area. One group of professionals joined to establish six different homes in small cities around Boston, caring for a total of 35 adults and 14 children. Each of the homes had in common the features of community support, formation as corporations, house-parent training, and careful management of vocational training and community relations to help the residents from State schools become reestablished in the community. Genesee Home in Flint, Michigan, as described by McNeil (285), was aimed at adjudicated male delinquents who could be controlled in the community. The house was operated by professionals who did not live in the house but worked 8-hour shifts. The five staff members were supervised by a professional social worker. Every attempt was made to involve the boys in decisionmaking and to encourage the boys to change their own patterns of behavior. Restriction of free time was the only punishment used.

In these four programs, close attention was given to reproducing

"parenting" processes of a normal family. Every effort was made to provide constructive substitute experiences for residents or clients in each program.

Other social development projects aimed at specific vocational goals or interpersonal skill goals may be noted. Nooe (313) described a vocational training program for mentally retarded young adults. The first group of eight residents were trained by a staff including a doctor, four counselors, and some volunteers. After an unstructured orientation period, emphasis was placed on finding a job for each person and on enlisting each resident in household chores and cooking responsibilities. A house meeting for business and a class on skills of daily living were held once a week. Other reports emphasizing vocational goals included one by Grimberg and Franzen (164) on a simulated money society as a predischarge service in a mental hospital. Wiernasz (443) described a similar "quarterway" house where mental patients were given practical counseling and were paid small amounts for chores and for satisfactory completion of treatment.

Social development programs in many cases focused on interpersonal skills, such as speaking to others or handling conflicts. For handicapped groups, the program consisted of simply exchanging ideas about current topics in a social conversation. For example, O'Connor (315) described a Creative Living Center to help mentally ill persons to stay in the community. Medical or paramedical treatment was not provided. The weekly program provided dancing, problem-solving groups, role playing, creative writing, outdoor sports, and other opportunities for participation. After each activity, an effort was made to elicit from each participant the personal significance of the finished product. Despite the fact that this group only met once a week, the staff believed it was effective in helping participants become better adjusted to their community. Among other programs focused on interpersonal skills, Lewis (250) reported a program in a geriatric center demanding maximum patient participation in planning occupational therapy. Another geriatric program reported by Rathbone-McCuan and Levinson (347) was in a daycare setting and offered socialization therapy to aged residents who were highly impaired in their social role performance but not comparably impaired in physical functioning. After 2 months of group interaction in which new roles were sought, many women developed helping attitudes in the group. Participation in all aspects of day program increased. Several other reports described programs of open discussion or guided cultural activities meeting only once a week; authors of these reports claimed observable positive changes. A report of a socialization group to prepare mental patients in leaving the hospital by Spence et al. (405) noted the main reason given by patients for not leaving the hospital was that no living

arrangement was available and that their own families did not support this move.

Research on Length of Treatment

The question of factors associated with amount of help received was subject to a number of investigations. Most studies concerned length of stay in mental hospitals, or number of readmissions to mental hospitals. In other studies the variable, amount of attention or treatment, was defined as time in the community before readmission, recidivism of delinquents, readmission rates, number of outpatient interviews, or total days under care in a given time period. All these variables were considered to reflect amount of help.

The design of these research projects was "effect-to-cause"; that is, groups of subjects were identified which received greater and smaller amounts of attention. Then a search was made for factors which would differentiate the groups.

A group of 19 reports—by Carpenter and Bourestrom (79), Eaton (110), Ellsworth et al. (114), Fanshel (120), Klein (225), Labreche et al. (230), Linn (251), Lorei (257), Lorei and Gurel (258), Lorei and Gurel (259), Maas (268), Maisel (270), Neff and Koltuv (309), Peretti (328), Roberts et al. (357), Serban and Thomas (385), Simon et al. (399), Stotsky (412), and Stotsky (413)—gave findings related to differences in amount of help. Most of the studies dealt with mentally ill and hospitalized persons, and most of those with chronic schizophrenic patients.

It was remarkable that among 17 studies where reduction of care was the dependent variable of interest, the past history of care was identified as a key preceding variable in no less than seven of the studies. In several of the studies past care proved to be the only substantial factor in predicting later care. This relationship was found for three different target groups and for several different methods of operationalizing amount of care.

The first of the 13 length-of-care pieces concerning the mentally ill was by Carpenter and Bourestrom (79). They reported that among 78 older ex-mental patients, those in more tolerant social environments were returned to the hospital much less often in the first year after discharge. On the other hand, ex-patients in tolerant situations reported less social participation, supporting the contention that higher expectation does lead to higher performance. Eaton (110) reported a curve-fitting analysis using data on occurrence and reoccurrence of hospitalization among schizophrenics from the Maryland Psychiatric Case Register. The number of episodes in earlier and later years was not correlated. Analysis of discharge

data, ward ratings, and other characteristics for over 2,000 patients in 19 Veterans Administration psychiatric wards, as reported by Ellsworth et al. (114), showed that the proportion of chronic patients on each ward was negatively correlated with release rates. In further analysis to isolate the effect of ward milieu, it was found that wards with higher release rates tend to be those with low autonomy of patients and negative staff attitudes toward the wards. On wards where discharged patients had low readmission rates, nursing staff did not feel dominated by professional staff and considered themselves active participants. A followup of a cohort of chronic patients in one county after 18 months showed that those chronic patients staying in the community tended to have functional diagnosis, rather than organic diagnosis, and also had less prior hospitalization. Staying in the community was *not* related to sex or age. Three statistical studies of different and successively larger Veteran's Administration patient groups by Lorei and Gurel (257, 258, 259) sought explanations for both community tenure and employment among discharged veterans. Results of the three separate analyses did not fully confirm each other. In the earliest analysis (257), it was shown that a factor representing objective distress, nonconforming behavior, and self-depreciation was positively related to readmission. In the second analysis (258), a personality inventory proved of no use in predicting readmission. The third and largest study (259) indicated that employment after discharge is best predicted from the patient's employment record and that readmission after discharge is best predicted from amount of past hospitalization. In an attempt to identify factors associated with length of community tenure, Maisel (270) interviewed 63 ex-patients identified earlier in the Hollingshead-Redlich study. Normal or conforming behavior was an important factor, and being employed was also an important factor, possibly associated with community tenure independent of behavior. A second interview study was reported by Peretti (328) which indicated that the profile of the ex-mental patient not able to stay in the community included not having a job, being a loner, and having negative self-image. Ex-patients' use of medical and aftercare service was examined along with other factors in a followup of 419 schizophrenics reported by Serban and Thomas (385). It was found that readmission was correlated independently with three factors: nonuse of medication, poor clinic attendance, and lack of employment. Examination of hospital records of 102 male schizophrenics placed in foster homes in the early 1960s, according to Simon, Heggestad, and Hopkins (399), indicated that both being older and having a history of less mental hospital care were associated with staying out of the hospital. Two studies by Stotsky (412, 413) examined factors that might help explain why some ex-mental patients adjusted to nursing

homes while others did not. In one study (413), it was found that threatening or violent behavior by patients was a primary factor in return to the mental hospital. In a later study where nursing home administrators and others were interviewed, there was indication that greater visitation by patients' families and a milieu where nurses were less authoritarian were both associated with continued and satisfactory tenure in the nursing home.

Two studies concerning juvenile delinquents were found. Klein's findings (225) suggest that labeling by police is associated with recidivism. Roberts et al. (357) found, in a series of studies on length of care among 455 first admissions to a State school for delinquents, that being younger and being previously institutionalized were associated with subsequent recidivism. Personality, intelligence, and other personal characteristics did not predict recidivism. Personality characteristics, especially impulsivity, were associated with recidivism.

Length of foster care among dependent children was the dependent variable in two reports. Maas (268) reported a followup study of children in foster care for 10 years or more. In general the long-term-care children were disadvantaged in social status, handicap, family organization, and mental ability. The strongest single factor in predicting final disposition of the child was length of time in care. A more recent report by Fanshel (120) which followed over 600 children for 5 years found that just over half had been discharged. Factors associated with discharge were parent visiting, positive evaluation of mother, and degree of activity of caseworker. Those 20 or so children transferred to treatment institutions tended to be older and to have suffered from neglect and abuse.

In three studies, amount of service received was operationalized as high or low levels of utilization of outpatient service. The more substantial study of the three reported by Labreche et al. (230) used data from the Monroe County, New York, Psychiatric Case Register on 200 male schizophrenic patients. Psychiatric and social ratings of patients and their situations were also collected. Social class was positively related with degree of involvement in outpatient treatment, while personal and other factors did not seem significant. I[illegible] (251) found that college student use of outpatient services was greater among students less integrated into traditional social institutions with clear role expectations. Neff and Koltuv (309) found that continuation in a rehabilitation program by ex-mental patients was associated with the personality qualities of being less impulsive, less naive, and less self-deprecatory.

In these studies, searching for explanations of variation in amount of help received, the one factor turning up repeatedly was prior experience. Is this finding a result of the fact that among those being helped there are a few chronic or severely ill or intractable persons

who need help again and again? Or is it rather true that the experience of being in the client or patient role disables one for normal living and increases the probability of more service?

Research on the Segregation of Children Who Need Help

Should those who need help be kept among others like themselves? Is it more humane to keep mentally disturbed persons in protective settings? Do handicapped persons have a right to protection from the exigencies of association with those not handicapped? Does the general public have a right to be free of the company of convicted criminals, deviants, and disturbed persons?

The issue of segregating groups from society, as a prerequisite to helping them, is of current interest. Movements for community care and deinstitutionalization have the premise that those needing help should not be segregated. The issue of segregation applies to all the groups covered in this review: juvenile and adult offenders, mentally handicapped, and others.

In this review, the issue of segregation was attacked directly for only one target group—mentally and emotionally handicapped children. There were 10 reports of evaluative research—by Carroll (80), Flynn and Flynn (134), Glavin (149), Glavin et al. (150), Hewett et al. (183), Jenkins et al. (200), Vacc (424), Vacc (425), Walker (432), Ziegler and Hambleton (454)—on this general topic. The studies tested whether it is advisable to separate handicapped children in special classrooms, whether handicapped children should join regular classrooms, or whether some modification of the usual classroom setting is most effective.

A report by Carroll (80) indicated that the educable mentally retarded (EMR) children in a segregated or special-class setting show less improvement in their self-concept than EMR children in a partially integrated setting. The Ziegler and Hambleton (454) study found that there was no statistically significant difference between segregated and nonsegregated "trainable mentally retarded" children in the adequacy of their social behavior. The Flynn and Flynn (134) study contrasted educable mentally retarded students in a part-time special program with similar children in regular classes and found no difference in ratings on a "school adjustment scale." The earlier Vacc study (424) indicated that handicapped children in special classes had better academic achievement and further that the handicapped children in regular classes were not as well accepted by their classmates as other children. The later study by Vacc (425) showed that the additional educational achievement among the special class children demon-

strated in his earlier report could not be expected to last beyond the actual placement in the special class.

A group of five reports, by Glavin (149), Glavin et al. (150), Hewett et al. (183), Jenkins et al. (200), and Walker (432), dealt with the physical and educational design of the classroom, the tasks set for children, and response contingencies. Three of the five reports described experiments with classrooms for behavior problem or disturbed children, while the other two dealt with classrooms for educable mentally retarded children. The report by Hewett et al. (183) describes design of a classroom with behavior modification methodology, tested against other educational methods. Arithmetic performance was improved by the experimental condition. The results for task attention were ambiguous. Two reports on behavior problem children assess the "resource room" as an alternative to special class placement. Children exhibiting problems were assigned to the resource room for differing periods of the day where they received remedial and special attention. The original report by Glavin et al. (150) was encouraging, while a followup 2 years later by Glavin (149) was negative. Two reports by Jenkins et al. (200) and by Walker (432) concerned educable mentally retarded children in resource rooms and indicated, respectively, that tutoring produced better academic achievement than small group teaching and that results from the resource room program in academic and social behavior were not better than results from special classes for educable mentally retarded children.

Results of these studies are mixed, and no policy directive emerges.

CHAPTER 3

SOCIAL INTERACTION IN HELPING

What is known about social relationships in alternative contexts for helping? What patterns of social interaction can be observed in the provision of long-term care, or day programs in the community? To what extent do caregivers and those needing help interact with each other? Are certain role prescriptions prevalent? Can role prescriptions be changed in newly designed programs?

Many of the reports reviewed indicated that rates and quality of social interaction had significance for the outcome of helping. Measures of social interaction were used in several studies. These reports are reviewed in the first part of this chapter. The topic of socialization or learning to enact new roles is the second major part of this chapter. The question of how people needing help can be socialized into more satisfying or more productive roles received attention from many investigators. The third major part of the chapter addresses the question of designing new social contexts for the giving of help. Can new situations be created so that interaction between caretakers and those helped will be mutually satisfying and productive?

Frequency and Quality of Social Interaction in Helping Contexts

A search was made among all the abstracts for relevant findings in the area of mapping out the social interactions in helping contexts. Studies were identified which focused on social interaction in some fashion. Social interaction was most often defined in terms of frequency of interaction among specific persons or length of time occupied by the interaction. In a few research reports there were attempts to observe the quality or the style of social interaction. Conceptualization and measurement in this area of research are not well developed, yet positive findings suggest that research efforts would be rewarded.

Description of social interaction was a primary or secondary concern in reports by Bartak and Rutter (22), Bjaanes and Butler (44), Brown (64), Buckey et al. (65), Buehler et al. (66), Calkins (74), Carpenter and Bourestrom (79), Dick (102), Dinwiddie (104), Donlon et al. (107), Edgerton and Bentz (111), Feldman et al. (124), Holzman and Sabel (195), Lawton et al. (237), Loew and Silverstone (256), Lubow et al. (262), Maisel (270), Mannino and Shore (272), Peretti (328), Rosenhan (361), Saltz (370), Sarata (376), Wagenfeld et al. (430), and Zahn (451). Social interaction was more often a secondary than a primary objective of the studies. For example, "social contacts" was often included among variables that might affect rehospitalization. A few investigators went beyond description to search for correlates of amount or type of social interaction.

A typical definition of social interaction, as time spent in verbal exchange by others, was used by Rosenhan (361). Observations of "pseudo-patients" for six hospitalizations showed that daily contact with all professional staff averaged 7 minutes. Six other studies used "amount of interaction" as dependent or independent variables, those by Brown (64), Holzman and Sabel (195), Lawton et al. (237), Loew and Silverstone (256), Sarata (376), Wagenfeld et al. (430). Frequency of face-to-face interchange was the most common measure of "amount" of interaction, followed by time spent in face-to-face interaction.

Quality or style of social interaction was addressed in a very few studies. A report of life in a physical rehabilitation center by Calkins (74) contrasted the staff view of time as "linear mechanistic" with several different views of time held by patients. Patients who were improving marked time around their progress. Other patients marked time by daily routine or simply by television programs. Older, long-term patients were nearly unoriented to time. Calkins defined six styles of use of time: passing time, waiting, doing time, making time, filling time, and killing time. Use of time would be one method of portraying role behavior by patients vis-a-vis staff. Bjaanes and Butler (44) also focused on time in observations of four facilities for mentally retarded. Two dimensions of use of time were "spontaneous-bland-routine" and "structured-unstructured."

Three systems of observing relations between staff and clients were based on program goals: The Work Behavior Observation Scheme of Lubow et al. (262) in a sheltered workshop, teacher activity as "instruction" or "playing" reported by Bartak and Rutter (22) in a unit for autistic children, and time spent in employment by the elderly by Saltz (370).

Quality of family relations and positive or negative affective interactions were focused upon in a number of reports. Dinwiddie (104) discussed the importance of capacity for "reciprocity of emotional transaction" in planning for children. Reports by Bartak and

Rutter (22) and Buehler et al. (66) measured acts of approval or disapproval directed at residents in schools for the retarded or other facilities.

What factors are associated with frequency and quality of interaction? Bjaanes and Butler (44) found that retarded residents of community facilities with freedom of movement exhibited more social confidence in normal interaction than residents under restrictions. Intra-institutional room transfer of 48 elderly residents was studied by Lawton et al. (237). Relocation resulted in more passivity, decrease of social interaction, and decrease in moving about the premises. This decrease in social activity was interpreted as resulting from a need to reorient oneself to the new environment. Zahn (451) reported that limitations in ability to communicate, work, and have sexual relations seemed to affect social relations negatively: the more visible the impairment, the more the effect. Brown (64) found more patient interaction in psychiatric wards where the need for patient interaction is stressed and rewarded, where the patient population was not severely disabled, and where differences in rank and authority were not emphasized.

Rate or style of interaction was shown by a number of studies to be related to ability of psychiatric patients to stay out of the hospital. Interaction was also found to be related to the morale or satisfaction of older people in long-term care. Mannino and Shore (272) found that ex-mental patients who lived in families of procreation, who occupied central family positions, and whose families were intact were better adjusted. Wagenfeld et al. (430) showed that ex-patients with more leisure and social contacts of all kinds had less pathology and shorter hospital stays. Studies by Buckey et al. (65), Carpenter and Bourestrom (79), Feldman et al. (124), Maisel (270), and Peretti (328) showed that higher levels or higher quality of social interactions were associated with better adjustment of ex-patients or with longer tenure outside the hospital. Similar positive effects from increased social interaction, in this case among the aged, were reported by Edgerton and Bentz (111), Holzman and Sabel (195), and Saltz (370).

Learning to Enact New Roles

Many helping programs—in fact all helping programs except "maintenance"programs–can be looked at in terms of socialization processes. Can new roles be taught in a program setting? Do some settings have negative effects?

"Negative socialization" means the adoption of less socially integrative or less independent role behavior. Only a handful of reports were found, noted in detail because of their significance. Authors of

reports included Alexander and Parsons (7), Booth and Babchuk (48), Buehler et al. (66), Bullington et al. (67), Giovannoni and Gurel (146), Hamilton (174), Heckel et al. (177), Karen and Bower (213), Kennedy (219), Klein (225), O'Connor (316), Raskin and Dyson (346), and Walker et al. (433).

Booth and Babchuk (48) interviewed 800 noninstitutionalized older adults to discover the sequence of decisions and actions in obtaining medical care. Advice was sought only when social functioning was threatened. Only one individual, usually, was consulted. Except in emergencies, the individual consulted was apt to be an acquaintance having personal experience with the health service in question rather than a professional. Subjects were influenced by practical advice and instructions. Acquaintances who proposed diagnosis, evaluated care, and made specific recommendations for care were more influential than acquaintances whose reaction was emotional or nondirective.

Buehler et al. (66) reported studies of negative socialization among adolescents in residential settings. In three related studies, responses of delinquent peers to delinquent role behavior were investigated. In the first study, it was observed that most social reinforcements for delinquent behavior were positive and that most reinforcement was supplied by other delinquents and not staff. A second study cataloged all positive and negative reinforcements for delinquent and for appropriate behaviors among girls in a State institution. The second study confirmed that responses to delinquent role behavior by peers were more often positive than negative, while peers punished socially conformed behavior more often than they rewarded it. The third study indicated that staff members tended to reinforce and to punish delinquent behavior indiscriminately.

A report by O'Connor (316) indicated an interaction between context and previous orientations of delinquent boys in negative socialization. Among 60 delinquent boys tested for socialization at two time periods after initial detention, it was found that initial negative attitude of the boy, when combined with a custodial (rather than therapeutic) institutional context, produced negative socialization. In reporting the experience of pseudo-patients in 12 mental hospitals, Rosenhan (361) identified three mechanisms leading to depersonalization or negative socialization. First was public fear and distrust; second was impersonal style of staff interaction with patients; and third was institutional practices, such as excessive recordkeeping, drug therapy, and interminable staff meetings. These interpersonal and contextual mechanisms were considered by Rosenhan to be more important than physical restraints in producing negative socialization.

Mechanisms by which "positive socialization" may occur were also suggested by several reports. Karen and Bower (213) analyzed the Synanon program for rehabilitation of narcotic addicts and

showed that most features of the program could be interpreted as applications of operant-conditioning principles. In the process of constructing this argument, the authors provided a summary of social interaction and context of the seminar program. Entering members were required to give up money, car, and driver's license, to restrict contact with family and friends, and to give up usual recreations. These activities and contacts are restored after good behavior. The rules of the program defined good behavior and specified consequences for behavior desired and not desired. Physical and health needs are supplied without question. The addict's status as a member continues as long as the member is willing, despite negative behaviors.

Kennedy (219) analyzed the Egyptian Nubian Zar ceremony to account for its effectiveness with various mental disorders. A complete context or role set is created in which normal expectations and sanctions are stripped away. In an extensive and exhausting ritual, elements of faith, suggestion, catharsis, and group support are combined. Kennedy reports remarkable results in changing mental states and role behavior.

Alexander and Parsons (7) reported success of an experimental program in changing communication patterns and social interaction in families of delinquents through a behaviorally oriented approach. New goals and rules for the family were clearly defined and monitored. Subsequent recidivism rates for juveniles in families of the experimental group were reduced significantly as contrasted with those of the other groups. Bullington et al. (67) recounted an unusual effort to change role behavior and social attitudes of addicts by giving them jobs and a respectable income for social service work with other addicts. Addicts did adopt elements of middle class outlook and values. From the viewpoint of the service program, there was a question of whether the workers could maintain their ability to work with lower class and disorganized addicts. Guthrie and Gasdick (169) described a detailed training program for chronic mental patients. The training program involved chronic patients in learning how to plan menus, buy foods, keep house, maintain personal grooming, speak with other people, and generally perform normal role behaviors. A special setting was created, a regime of role practice and chores was established, and there were public recognition and progression of patients through several stages of social performance. A report by Klein (225) on police diversion of juveniles in Los Angeles County suggests another kind of positive socialization which might be called nonlabeling departments, where a higher proportion of juveniles who were diverted and not charged also tended to have lower rates of subsequent offenses.

These research reports on positive and negative socialization recall the characteristics of successful "absorbing" treatment programs noted in chapter 1. Behavior expectations or role prescrip-

tions were made clear to all involved in the role set and, furthermore, were carefully monitored and watched. A new environment with clear structure was established. A completely new role set was often, though not always, created. Frequency and consistency of social interaction, all supportive of the new role prescriptions, were high, and social isolation was avoided. Finally, there was a reliable regime of activity as the social matrix in which participants practiced the prescribed role behaviors.

Hazardous or problematic behavior by individuals needing help was addressed in a few studies. An important issue in public reaction to mental patients and others needing help is whether they are so dangerous to the community or such a burden to their family that they must be "put away." A few items were found which provided evidence on the question of hazard and burden.

Giovannoni and Gurel (146) followed over 1,200 discharged Veterans Administration mental patients to determine the extent of socially disruptive behavior. A total of 156, or 12 percent of the discharged patients, were involved in 192 incidents. About one-quarter of the 192 incidents were offenses against persons. Sexual offenses were only 8 percent of all incidents. Two-thirds of the offenders were diagnosed as having an alcohol problem as well as being schizophrenic. Heckel and Reeves (177) reported interviews of 887 newly admitted mental patients in South Carolina, or their families, to determine social situations at onset of problem. Personal characteristics, work, and mental history did not show gross deviation from normal populations. Problems leading to hospitalization seemed to come most often from social behavior in the family context, not from violation of community norms or criminal behavior.

A few other reports were based on collection of social histories or interviewing of smaller numbers of mental patients. Raskin and Dyson (346) were interested in social situations and behaviors leading to readmission of schizophrenic patients. Readmissions were attributed to change of therapists and to isolation and loneliness of some patients. It was noted that of 45 consecutive readmitted patients, there were 16 who had never become involved in aftercare. Twelve of these 16 had been readmitted because of socially disruptive behavior; these were patients who had run away from the hospital or had convinced their families to sign them out against medical advice. Of patients unable to remain out of the hospital, approximately one-third exhibited unacceptable or socially disruptive behavior. Walker et al. (433) compared patients seen in a crisis service who were referred to outpatient vs. inpatient treatment. Patients referred for inpatient treatment, or about one-third of the total 75, were more hyperactive, more distrustful, and more disorganized in social processes. An English study reported in part by Hamilton (174) investigated both objective and subjective burden imposed on families by 273 ex-mental patients. Objective burden

was defined first as adverse affects on family welfare functioning and second as abnormal or disruptive behavior by the ex-patients. Less than half of the families experienced any objective burden. Three-fourths of the families experiencing objective burden also experienced subjective burden, but only one-fifth of those families rated as "severe."

These studies of community burden and of disruptive behavior by persons with mental problems are provocative but do not permit any conclusions. There is a minority of persons with serious mental illness who present problems of integration or accommodation in family and neighborhood. It may be that this minority of mental patients is not accessible to the programs of social integration or positive socialization processes described in this report. In view of the widespread and growing resistance to community placement of mental patients, better descriptive studies of this problem are justified.

Designing New Social Contexts

Definition and deliberate creation of helping roles and of new role sets were the subject of 21 items covered in this survey. The work reviewed here is oriented to discovery of strengths in "natural" situations and to the creation of new situations which preserve those strengths. If principles of positive social contexts can be found, then one could design more helpful situations.

The reports on helping roles fell naturally into three groups. The description of *new helping roles* included reports of helping persons and their behavior and analysis of personal characteristics associated with helpfulness. A second group included pioneer efforts to determine *quality of context.* What is a helpful situation? Finally, three studies concerned *modification of family and community "natural" role sets to help people.* Reports relevant to these questions include articles and books by Arnson and Collins (13), Clabert and Baltzer (73), Chien and Cole (83), Elpers et al. (115), Gazan (143), Goodman (155), Greiff and McDonald (163), Kelly (218), Kent and Hirsch (220), Lawton (235), Miller (294), Moos (298), Moos (300), Mosher et al. (303), Osborne (320), Otto and Moos (321), Otto and Moos (322), Severn and Mendelson (386), Shapiro (388), Skipper and Leonard (400), and Woodbury and Woodbury (449).

New helping roles were the focus of several reports of research or program experience. Shapiro (388) described natural leaders among six SROs (single-room-occupancies) housing over 100 alcoholics, addicts, ex-mental patients, ex-prisoners, elderly, and disabled welfare recipients in New York City. Most residents were members of one or more cliques for social support. Although many clique leaders were exploitative or even sadistic, three women

among the clique leaders were known to be warm, expressive, outgoing, and willing to help in many ways. All three women were black, age 40-55, alcoholics, chronically ill, with high school education, which was more education than most of the residents had. These leaders helped residents obtain cigarettes, helped control and monitor disruptive behavior, and in particular mediated between these individuals and other residents or community agents. Social workers from the local mental health center first attempted to compete with these women and then collaborated with them. Kent and Hirsch (220) described the use of "indigenous workers" as research interviewers in a study of problems of low-income, minority-group aged. Results were satisfactory from a research point of view, and it was suggested that these indigenous workers might have a broader role in community organization and help. Chien and Cole (83) reported how landlords were recruited and assisted to become supervisors and helpers of chronic schizophrenics outside the mental hospital in cooperative apartments. The role of the landlord in the early stages was to provide whatever food and supervision were necessary to maintain patients outside the hospital until they gained more confidence. Skipper and Leonard (400) reported that when mothers of children confined in a large teaching hospital for surgery were subjected to interaction with a special nurse several times during the day, the children showed significantly better patient behavior. Measures of better behavior included lower temperatures, lower pulse rates, lower blood pressure, less disturbed sleep, less evidence of fear of doctors and nurses, and shorter recovery period. These findings suggest, as do the above, that community caretakers can be part of a professional helping program.

Several other reports focus on characteristics of persons in new helping roles, rather than on the role relationships. Severn and Mendelson (386) reported that among 140 caretakers, "sociability" and "self acceptance" of caretakers, as measured by the California Psychology Inventory, were related to positive ratings by social workers for caretaking ability. "Social presence" was negatively related. These findings might suggest that persons who can fill nonprofessional helping roles are sociable and self-effacing rather than self-aggrandizing. A related study by Mosher et al. (303) analyzed the personal characteristics and background of workers in Soteria House, a program for treatment of young schizophrenics which was reviewed in chapter 1. Among the first 10 workers employed for this program, staff members were similar to residents; their mean age was 28 years, and most were single. Social class background was middle and working class; most had some college and on the average 3 years' experience in mental health work. However, the most striking feature was that 9 of the 10 workers came from families with an alcoholic or disturbed parent.

All 9 of these young people had acted as benign and stable caretakers of a parent or sibling but had not themselves broken down. Two other reports are suggestive, although neither supplied information on program outcome. Goodman (155) described the design of a research project where three adolescent boys having interpersonal problems were matched with volunteer counselors on the basis of "quiet" and "outgoing" personality characteristics. Greiff and McDonald (163) outlined a program where a treatment team in a geriatric daycare center including nurses, attendants, and social worker all act as leaders of groups for occupational therapy, psychodrama, and recreation. Elpers, Miller, and Owen (115) described a program of group therapy for psychiatric aftercare which was focused on increased self-reliance of patient and the formation of positive relationships with persons in the community rather than persons in the treatment group.

In summary, the various reports on new helpers and new helping roles suggest a great deal of experimentation. Identification of personality characteristics for effective helpers and specific matching of types of helpers with types of problems are questions receiving attention from several researchers.

Quality of context in helping organizations was the focus of a small group of reports. Work in this area represents an early stage of development. Kelly (218), in an interesting essay, suggested that interaction between individuals and organizations might usefully be conceptualized with notions from field biology. Among principles for application to the school environment is the ecosystem principle of interdependence, cycling of resources, environmental structuring of access to nutrients, and the principle of succession. A report by Arnson and Collins (13) from an experimental rather than a theoretical perspective expressed a relevant notion in the program principle that patients in a metropolitan community mental health center related to the center rather than to any one staff member. This principle was implemented by including patients in staff meetings and professional conferences and by maintaining a variety of therapy and interest groups. Lawton (235) seemed to be suggesting a similar strategy in an institution for the elderly where specially selected and trained personnel were introduced to wards of senile "hopeless" patients. Since staff were specially selected and trained, morale was high, and the attitude and role behavior of staff without any other interventions seemed to lead to much improvement and hopefulness among patients. In a report by Miller (294), still another related notion is developed from program experience. In a psychiatric emergency service, there was careful attention to the social environment or ecological group of each patient. Social environment includes all of the people in each of the social systems important to the patient at the time of the emergency. Intervention

and referral were guided by analysis of the social situation. Gazan (143) describes ad hoc creation of new roles and role sets in a rehabilitation camp for delinquent boys in Michigan. A camp council of six boys was selected from the total population. Experienced boys were assigned to new residents as "big brothers"; it was thought that this experience was positive for the big brothers in particular. In short, there were several examples of interesting attempts to modify organizational roles and role sets so that impact on those needing help will be more constructive.

The work of Moos and his associates represents the most ambitious attempt to define the organizational environment more specifically and to measure its quality and impact. A 1972 report (298) described development of COPES or the Community-Oriented Program Environment Scale. Items were adapted from an earlier Ward Atmosphere Scale developed for institutional settings. COPES was an attempt to define and measure the dimensions of psychosocial environment in transitional community-based psychiatric programs. Ten dimensions or subscales included program involvement (of patients), support (by staff and other patients), spontaneity, autonomy, practical orientation, personal problem orientation, anger and oppression, order and organization, program clarity, and staff control. A report by Otto and Moos (321) used COPES as a framework for evaluation of five public descriptions of community-based psychiatric programs. As a result of this analysis, the authors recommended six dimensions for use in program description: physical design, behavior settings of treatment, organizational factors such as size and cost, personal characteristics of patients and staff, psychosocial climate, and analysis of reinforcement in the treatment program. A 1974 report by Otto and Moos (322) used COPES to measure expectations held by patients entering different psychiatric services and subsequently their reaction to the program after experience in it. Findings were interpreted as showing that level of expectation in certain areas may condition later reaction. A 1976 volume by Moos (300) sought to draw together theories from several fields on the relation of environment and human behavior. A chapter on social climate of the environment broadens the application of a grouping of the COPES dimension into three groups: relationships, personal development, and system maintenance or change. It is suggested that these three factors usefully describe such diverse environment as families, university living groups, psychiatric treatment programs, and classrooms. Further, three outcome criteria of the effects from social environments are suggested: (1) satisfaction, moods, and performance; (2) objective measures of achievement from study or work; (3) measures of health.

The modification of family and community "natural" role sets to

help people was the theme of three reports. Calbert and Baltzer (73) described an attempt to change family climates for physically handicapped children by the use of home visits lasting from 1 hour to several days. The purpose of the home visit was to permit the professional to learn everyday interaction patterns of the family and to suggest modification to assist language development of the child. Osborne (320) described the Nigerian practice of encouraging villagers near mental treatment facilities to take in mental patients, along with patients' family members, during treatment. The intent was to avoid cultural shock and the negative effects of entering a treatment institution, while maintaining some primary group support. Woodbury and Woodbury (449) described psychiatric treatment teams in Paris, including psychiatric social worker, visiting nurse, and homemaker. These teams went to the home of the patient and sought to teach a "normal" model of family living and problem solving.

CHAPTER 4

VALUES AND HELPING

What is known about values toward those needing help? What attitudes are held about different contexts for providing help, such as community or nursing home or State institution? Over 100 research reports and essays were found on values and attitudes relevant to helping. Two-thirds of the reports are concentrated on the topic, *values and attitudes toward those who need help.* Do people tend to sympathize with those needing help, or are they scornful? Do social class and other attributes combine with being in need of help to affect attitudes? A second topic is *labeling of those needing help.* Do diagnostic or legal labels carry negative value? Do these labels stick to people? Do labels themselves come to influence social relations? A final section reviews research on *values concerning contexts of help.* What values are held regarding different helping situations? How do people view mental hospitals, for example?

Values Concerning Those Who Need Help

A total of 74 items were found concerning values toward the handicapped or chronically ill or other target groups needing help. Most of the research work on "values and helping" concerned attitudes toward those helped. This review is further subdivided in terms of the question: What group holds the values or attitudes in question? The subdivisions are made in terms of whether values and attitudes toward those needing help are held by the general public, by school children, by persons needing help, by family members, by teachers, or by other professional helpers.

Values and attitudes held by the general public toward those who need help were of interest in 13 reports, all but three of which have to do with mental problems. A careful study by Dohrenwend and Chin-Shong (106) touched on three questions concerning public attitude toward mental illness. What are public attitudes toward mental illness? Are public attitudes changing? How do the atti-

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tudes of various social classes differ? A survey of public responses to six brief case descriptions showed that tendency to impute mental illness had increased from earlier studies. Seriousness of psychopathology was assessed independently of seriousness of threat. Higher, more than lower, social class persons agreed with responses of psychiatrists.

Bord (49) and Olmsted and Durham (318) also reported that images of threat or disruption were prominent in public attitudes toward mental illness. On the other hand, Bentz and Edgerton and others (30, 31, 32, 111) reported that a majority of the general public in selected North Carolina counties, as well as leaders in those counties, exhibited enlightened attitudes toward the mentally disordered and agreed that "it is usually better for the mentally ill persons to receive treatment in the community than in a mental hospital." Kirk (221) reported research which suggests that the content of behavior, and not simply the mental illness label, determines the degree of rejection. Another report, arguing against the predominance of threat in public definitions, is by Jones (207), in which responses to vignettes portraying several different handicaps (physical, mental, learning) are analyzed. The structure of attitudes toward all groups was found to be singular, i.e., mental conditions were not "special" or "threatening."

Are public attitudes toward mentally ill changing? Dohrenwend and Chin-Shong (106) found by comparison with earlier studies an increasing tendency to impute "mental illness" to behavior descriptions. The Olmsted and Durham study (318) was interpreted as showing that negative attitudes toward the mentally ill, rooted in cultural belief systems, apparently did not change during the years 1962 to 1971. In a study by Goldbried et al. (152), 30 respondents, who reacted to a behavior description and were then given information to help them understand that behavior, exhibited somewhat greater understanding of behavior but maintained the negative rejecting evaluation of behavior. Although the public can "understand," the understanding does not necessarily increase acceptance. Attitudes toward those needing help are placed in a broader context by Levine's report (246) about questionnaire responses in Great Britain, Czechoslovakia, and West Germany. National differences in attitudes toward mental illness were thought to reflect respondents' general orientation to social issues, which in turn was reflective of the community climate in each country.

A third question touched on in a few reports was whether attitudes vary with social class. Dohrenwend and Chin-Shong (106) reported that persons of low status were not more tolerant of deviating behavior but were less apt to agree with psychiatric assessments of behavior. The studies conducted in North Carolina noted above by Bentz, Edgerton, and others (30, 31, 32, 111) also showed

that more educated and higher status people of the community had attitudes toward mental illness more similar to those of mental health professionals than were those of lower status citizens. Bord (49) turned the question around (i.e., behavior descriptions, not respondents, were of different class levels) and found that when the behavior descriptions concerned lower class people, there was more rejection.

A second group of studies had to do with the attitudes of school-age children toward other children needing help, i.e., toward children who were physically disabled, mentally retarded, or handicapped in some other way. Age effects were reported by Jones and Sisk (209) and by Richardson (353). The first of the research reports suggests that children become aware of handicaps at the age of 4, and the second suggests that by age 12 both boys and girls have developed attitudes much like their parents toward the handicapped.

A report by Alessi and Anthony (6) indicated no fixed order of attitudes expressed by students in response to vignettes portraying different levels of severity or type of disability. A report by Farina et al. (123) indicates a more sympathetic attitude among college students toward most disabled fellow students. Dion and Berscheld (105) show that physical attractiveness is correlated to popularity among children 4 to 6 years of age. Sex differences in attitudes toward handicap were found by Lazar et al. (239) and by Richardson (353). Chigier and Chigier (84) found in a study of over 1,000 boys and girls in Israel that children of lower social economic status reacted more strongly to cosmetic faults than to physical disability.

Several investigators reported findings which bear on policy and program questions in terms of changing attitudes. Richardson (354) showed that in a summer camp situation, group-expressed values and friendship behavior correspond with each other for normal children early in camp, but the reverse was true for physically handicapped children. Rapler et al. (345) found that children in grade school who had at least one orthopedically handicapped child in their classroom became more accepting of the handicapped during the school year. Marsh and Friedman (276) reported that a high school health education program about blindness produced more positive attitudes toward blindness. Lazar et al. (239) found that an instructional program featuring handicapped Americans produced more positive attitudes toward the handicapped among gifted than among normal children.

Seven research reports dealt with attitudes of students toward the mentally handicapped or disturbed. Most of the research concerned mentally retarded in the public schools and was oriented to the question of integration in regular classes versus provision of special classes. Findings in several pieces of research were inter-

preted as encouraging integration. For example, Feldman et al. (124) reported that when five antisocial boys age 9-12 were placed in mixed groups with larger numbers of prosocial boys, antisocial behavior of antisocial boys declined greatly with only a small increase in antisocial behavior by prosocial boys. Jacobs and Pierce (198) found that symptoms of brain damage (short attention span, hyperkinesis, and emotional lability) were closely associated with rejection of children in special public school classes. Jones et al. (209) showed that tutoring experience of 10- to 12-year-old boys and girls with trainable mental retardates increased their acceptance of the retarded children. Warner et al. (435) found that educable mentally retarded children in special classes did not resent their special class placement and did not report feelings of rejection and stigmatization. Children of high school age in special classes were much less often satisfied. Herr (179) found that college student counselors in a 1-week camping experience with severely emotionally disturbed adolescents developed more acceptance of deviance.

Three research reports tend to contraindicate integration of children needing help with other children in public schools. Iano et al. (196) showed that an integrative resource-room program did not produce more acceptance of educable mentally retarded children by schoolmates. Rucker et al. (365) used sociometric scales with about 1,000 junior high school children to show that the educable mentally retarded children were significantly less accepted than nonretarded in both academic and nonacademic classes. Further, the retarded children themselves tended to overestimate their acceptance in regular classes. Strauch (411) found that amount of social contact of normal adolescents with educable mentally retarded adolescents was related to positive attitudes of the first toward the second. Further analysis showed that this relationship could be explained by the attitudes of normal adolescents toward "normal people."

A group of six research reports dealt with attitudes of those needing help toward their conditions or toward themselves. With only one exception, these reports support the idea that persons needing help view themselves as different than others, view themselves in a negative way, and probably participate in developing deviant and negative definitions. Berry and Miskimins (40), as noted above, showed that psychiatric patients having lower self-concepts also tended to be less placeable in jobs. Farina et al. (121), also previously cited, showed that mental patients had more difficulty in performing synthetic tasks with experimental confederates when they believed the confederates knew their status as mental patients. Lerman (242) in an attempt to clarify the concept "subculture of delinquency" analyzed interview returns from over 500 youths. The interview returns suggested that attraction of deviating youth to values of the delinquent subculture begins at age 12 to 13;

high reports of past misconduct were correlated with attraction to deviant values and with association with other boys who endorsed such values. Levitan (249) suggested on the basis of interviews with critically handicapped persons in the waiting room of a large hospital that handicapped persons participate actively in their definition by others. Swanson and Spitzer (417) report that psychiatric patients in three hospitals seemed to stigmatize their fellow psychiatric patients more highly than any of the patients were stigmatized by other family and friends. Not supporting the notion of negative self-image was the report mentioned earlier by Foster et al. (136), indicating that boys having encounters with police or court around delinquent acts did not perceive stigmatization or social liability as a result of that contact.

Attitudes of families to family members needing help were described in several research reports. Six of the reports concerned attitudes of family members toward mentally ill children or relatives. Gove and Fain (157) in an analysis of mental hospital patient records found that family attitude was not important in determining length of hospitalization; Greenley (162), however, in a similar study made the opposite finding. Markson (274) used interview returns and other data on 174 elderly patients admitted to a New York State mental hospital to argue that these patients were near death when admitted and the mental hospital admission was the method for physician and family to rid the household or the hospital of that person. She reported that the definition of these patients as mentally ill began with the family in three-quarters of the cases. Michaux et al. (291) found that dissatisfaction with performance of psychiatric day-center patients by their families was higher in urban than in rural families. Pokorny and Bentinck (338) reported that of a random sample of 1,537 State mental hospital patients, over half were rated by professionals as being ready for release. Of the same group, only 20 percent of patients' relatives expected the patient to return home, and only 37 percent would have welcomed the patient if he or she did return. Ring and Schein (356), in a study based on interviews with adult members of about 400 households in a lower income black community in Philadelphia, showed that respondents indicated acceptance of mental illness in general but not if the ex-patient was within the immediate household.

Five other research reports in this group dealt with attitudes of family members toward mentally retarded or otherwise handicapped children. Birenbaum (41, 42) reported that mothers of retarded children tended to voice the need for independence by the child, while at the same time acting in overprotective ways. Mothers attempted to fit the child into the routine of the family with as little change as possible in public appearances. Fabrega and Haka (117) reported that parents of mentally handicapped children, representing about 50 families, were interviewed concerning their own

mental health and were found to score significantly less well than a large sample of the general population. Neuhaus (311), in interviewing and testing of deaf children and their parents, found that there was a relationship between mothers' and fathers' attitudes toward their children and their children's emotional adjustment. Wetter (438) reported that among 70 sets of parents registered at a pediatric outpatient clinic, mothers of learning disordered children were more indulgent, but not more overprotective, than mothers of normal children.

Attitudes of teachers toward students who are handicapped with mental disturbances or mental retardation were studied in eight research reports. Three research reports could most reasonably be interpreted as encouraging integration of handicapped students in regular classrooms. Gullotta (166) found that among 50 graduate students, most having teaching experience, there was a willingness to keep disturbed children in regular classrooms, if supporting services were available. Research reports by Combs and Harper (94) and by Foster et al. (135) both showed a negative effect among teacher trainees and teachers from labels indicating handicaps. These findings would tend to discourage the labeling of children and encourage integration.

Several other research reports could be interpreted as discouraging integration. Shotel et al. (393) surveyed elementary teachers in three schools who had children needing help in their regular classes with assistance available from a resource-room service. Teachers indicated the resource-room service had only a slight effect in changing teachers' attitudes. Smith and Greenberg (402) found that about 300 teachers endorsed the mental retardation labeling of a child more often when the descriptions of the children's behavior indicated that they came from a low social economic level. Salvia et al. (371) found that labeling as mentally retarded tended to increase acceptance of mentally retarded behavior descriptions but not of behavior descriptions of children needing help for other reasons. Fine (127) found that 13 teachers of educable retarded children were more accepting and less demanding of retarded children than 21 regular classroom teachers, according to questionnaire results. Payne and Murray (327), in surveying 50 urban principals and 50 suburban principals, found that urban principals were somewhat more reluctant to integrate handicapped children into regular classes.

Attitudes of professional helpers (psychiatrists, social workers, psychologists, nurses, and vocational counselors) toward those needing help were reported in 13 studies. The overall picture of attitudes and behavior of professionals toward those needing help contradicts the image of professional objectivity and professional neutrality. Attitudes of professional helpers, despite professional ethics and doctrines, seemed much like those of the general public.

When specific professional behaviors were studied, such as assignment for treatment or personal interaction with clients, the behaviors seemed to be conditioned by professional interests. Mendel and Rapport (288) analyzed 269 decisions for and against hospitalization made by 33 professionals. Recommendations for hospitalization were more frequent from psychiatrists than from social workers and were more frequent from the less experienced clinicians of all professions. Both previous hospitalization experience and severity of disorder were positively associated with recommendations for hospitalization, although the professionals interviewed denied considering previous hospitalization in their decisions. Lubin et al. (261) examined assignment of 611 adults applying consecutively to a community mental health center. Patients with less education and lower status occupations were more frequently assigned to inpatient service and less frequently to individual therapy. The majority of alcoholics and schizophrenics were assigned to inpatient service. Previous hospitalization was associated with assignment to hospitalization, as in the study just cited. Plutchik et al. (337) analyzed ratings by psychiatrists and social workers of 51 patients seen in an aftercare clinic to determine typical descriptors. Psychiatrists more often mentioned symptoms; social workers more often mentioned such phrases as "low self-esteem" and "family conflict" and more often mentioned strengths. Caetano (71) compared attribution of mental illness to video-taped interviews with subjects by psychiatrists and college students. The psychiatrists more often attributed mental illness to the subjects. Another study of team decisionmaking was conducted by Gunn et al. (167) among eight mental hospital teams of five professionals each. Questionnaires were completed for 10 actual discharges by each of the 10 teams. The general finding was that social and environmental factors were more important than administrative factors in the rating of the professionals. Another interesting finding was the "team effect" where professionals on the same team apparently agreed more with each other than with their professional colleagues on other teams. Still another examination of discharge decisions was conducted by Sternlight et al. (410) in a State school for the mentally retarded. One-third of about 1,000 residents were considered suitable for community placement. Family acceptance and conforming behavior by the residents were the major factor. Reid (350) found that among 88 social caseworkers, preference was given to insight-oriented techniques where clients were portrayed as being moderately disturbed as against severely disturbed. Schroder and Ehrlich (379), using vignettes and questionnaires, showed that psychiatric nurses tended to reject persons portrayed as mentally ill. But there was an independent "rejection effect," associated with greater behavioral disturbance, when persons were receiving help from such sources as mental hospitals. Loeb et al. (255) describe similar effects of

behavior descriptions in the case of vocational rehabilitation counselors.

Differences among social class of patients, as a factor in professional decisions, was noted in several reports. In a study of therapists' judgments about hypothetical patients conducted by Rowden et al. (363), 34 practicing and trainee therapists showed a preference for patients portrayed as having higher social class and higher insight and verbal ability. A study of several thousand discharges from community mental health facilities by Baldwin et al. (18) indicated that employment and occupation, and age and sex as well, were moderately related to diagnosis. Patients' race was even more highly related to diagnosis. Social status effects were also reported in two studies of actual social interaction between clients and their helpers. McGarry and West (281), in a questionnaire study of staff-resident interaction in a training center for the retarded, showed that staff intiated interaction most often with the more mobile, communicating, and attractive residents. Rosenhan (361), in describing experiences of several volunteers as pseudo-patients, reported frequency and style of staff-patient interaction. The rates of interaction were extremely low, totaling only a few minutes per day between professional staff and patients. Also, pseudo-patients reported that staff depersonalized the patients by paying little attention to their actual behavior or words. Marx and Spray (278) report that agreement on family and religious values may be more important than agreement in social class in establishing psychotherapeutic relationships between psychiatrists or psychologists and their patients in private practice. Questionnaire data came from psychiatrists and psychologists in several major cities. Wagenfeld et al. (429) found highest adherence to Community Mental Health Ideology (CMHI) scale in rural areas among centers having their own governing boards, among social workers and psychologists, and among those describing their organizations as social rather than medical. In summary, professional helpers, like the general public, tend to stereotype their responses toward persons needing help.

Orientation of professionals toward community programs and toward involvement in family and other social support systems of clients was also investigated. Three research reports had to do with the Community Mental Health Ideology (CMHI) scale. Baker and Schulberg (17), in a report on development of the CMHI scale, claimed validity in that respondents with higher scores spend more of their time in administration, consultation, and teaching. More of the lower scoring respondents spend time in direct therapy and work in mental hospitals. Kramer and Young (229) report questionnaire results from about 100 professionals who had undergone training in community mental health. Gains in CMHI scores were

general. Half of the goals for their own work, mentioned by participants, concerned reorganization, consulting, and coordination.

Several research reports raise a serious question as to whether professionals are oriented to community and family practice. Armor and Klerman (11) investigated professional ideology of psychiatrists. Analysis of patterns of attitudes in over 300 responses indicated that somatotherapeutic and psychotherapeutic orientations were systematically related to other professional attitudes and to activities of psychiatrists, but that sociotherapeutic orientation was not. Smyer et al. (404) reported that after 9 months of experience in a "therapeutic community," geriatric nurses' attitudes toward aged patients were still determined by "nursing care" values rather than by "therapeutic community" values. Segal (384) showed that public aid caseworkers had very little knowledge of the social situation or preferences of their permanently and totally disabled clients, and therefore were not in a position to plan developmental programs with clients. Davids et al. (99) reported on an extensive and unsuccessful attempt to use personality tests to identify more capable childcare workers already rated as more capable. Harris (175) reported the difficulties of educating doctors, nurses, psychiatrists, social workers, and others to higher expectations of heart patients and more appreciation of their social situation.

Labeling of Those Needing Help

The process of problem definition, or the societal response to those needing help, has been examined by several social scientists under the term "labeling theory." Eighteen reports from this review bear on the question of labeling.

Scheff, a spokesman for labeling theory, has surveyed evidence that supports and negates this theory (378) and concluded the weight is on the positive side. Although Scheff grants that the theory is ambiguous, poorly defined, and not to be taken literally, he contends that its basic ideas are important for social policy toward persons needing help. For example, the underlying assumption behind the case for integrative special education programing is that labeling theory is correct—the more that persons needing help are separated from others and labeled as different, the more their capabilities and their enjoyment of life are handicapped.

Scheff uses a broad definition of labeling theory; for purposes of the present review a simpler construction will be used. Research on labeling is defined here as: (1) research concerning the effects of a label and of itself, independent on the behavior or appearance which the label is supposed to signal; (2) research examining correlates of labeling; and (3) research concerning social psychological

events and processes, through which labels are proposed and accepted or rejected by actors, including the "labelee."

Berry and Miskimins (40) found that ex-mental patients who were vocationally placeable scored higher on self-concept than those not placeable. Caetano (71) reported that labeling of subjects in video-taped interviews as "mental patients" increased the probability of their being diagnosed as mentally ill by psychiatrists and college students. Combs and Harper (94) in a similar experiment found that educators expressed more negative attitudes toward persons when those persons were labeled as deviant, except for the retarded. Similar findings were reported by Foster et al. (135) for teacher trainees and by Loeb et al. (255) for vocational rehabilitation counselors and businessmen.

In an unusual report, Rosenhan (361) recounts experiences of eight pseudo-patients in 12 different mental hospitals. The staff in all of the institutions accepted each person labeled mentally ill as "mentally ill" without question; the volunteers themselves reported the experience as being disturbing and damaging to self-respect.

Several other research reports were found which elaborate labeling theory or suggest new directions of research. Swanson and Spitzer (417) submitted scales, designed to assess stigma, to 670 patients at three mental hospitals during inpatient episodes and also at postpatient phases of their "careers." Stigmatization of the mentally ill by other mentally ill was highest among inpatients and lowest among postpatients. Also, significant persons known to the patient were less stigmatizing than other inpatients. Farina et al. (121) found that 59 psychiatric patients working on a problem-solving task with confederates felt less appreciated and performed more poorly when they believed the confederates knew of their mental patient status. Baldwin et al. (18) constructed an index of "status inconsistency" and applied it to the records of over 10,000 patients in outpatient facilities. Race was highly related to diagnosis, but status inconsistency had virtually no explanatory power. Smith and Greenberg (402) showed that the labeling decisions of teachers of educable mentally retarded children may be influenced by status; the teachers tended to rate the students' profiles lower when the children were portrayed as being of a lower socioeconomic class. Farina et al. (122) reported that male college students reacted negatively to fellow students labeled as mentally ill and also personally responsible for the mental illness. Shears and Jensema (390) reported on 94 college students' responses to a social distance questionnaire with respect to vignettes describing 10 types of handicaps. As the social level of intimacy increased, the percentage of respondents accepting the disability decreased. Finally, Levitan (249) reported her interpretation of a number of interviews conducted with physically handicapped patients in the waiting room of

a large hospital; the handicapped took an active part in the labeling process by indicating to others how they wished to be defined.

Several other research reports could be interpreted as nonsupportive of labeling theory. Foster et al. (136) summarized interviews with 196 boys who had had encounters with the police. The boys did not report any substantial change in their interpersonal relationships or any evidence that court experience caused them to be stigmatized. Kirk (221) submitted behavior vignettes with different labels to community college students. Questionnaire results indicate labels did not lead to rejection of the mentally ill. Meade (287) used personal data and court disposition data from the cases of 500 juvenile offenders to show that there seemed no bias against recidivists. Salvia et al. (371) found that in the face of conflicting evidence about children's behavior, labels were retained on a selective rather than consistent basis by their subjects.

Research on labeling, as reviewed here, does support the labeling theory in the narrow sense that individuals needing help are tagged with negative terminology which reinforces a pattern of negative valuation. But labeling theory in the sense of propositions concerning correlates of labeling or a social process of labeling was neither propounded nor investigated to any extent.

Values Concerning Contexts of Helping

Attitudes and values toward contexts of helping were examined in 26 research reports and essays. Almost no studies of attitudes or values toward specific helping situations were found. Therefore, for this review, "context of helping" was defined broadly to include particular places, programs, or professional services. Even when defined broadly, not much research was found. In general, though, the research indicates that helping programs are not clearly understood and are not used in ways that professionals would like.

Research reports and essays are reviewed under four content groupings, according to whether the attitudes and values were held by those being helped, by older people, by families of persons needing help, or by helping professionals. An extensive review of research by McKinlay (282) was oriented toward methodological problems and therefore does not fall under any of the four headings.

Attitudes of those being helped toward helping programs and facilities were represented by six research reports. Attitudes of the public, as potential users of service, were included. An extensive survey of public image toward mental health services was carried out in New York City by Padilla et al. (324). Padilla and associates reported verbalized acceptance of the need for service, preference for immediate help, and aversion toward mental patients or mental

services, despite the verbalized acceptance. Fletcher (130) reported that referral recommendations of the public in response to case descriptions indicated that the public expect psychiatrists to play the moralist preceptor role, not the neutral physician role. Fletcher's observation supports the idea that people want services to be practical and relevant. McWilliams et al. (286), in a public survey in Tucson after the opening of a mental health center, found verbal acceptance of services, as did Padilla and associates. McWilliams et al. also found that respondents believe services were most necessary for drug problems and alcoholism; this finding reinforces the emphasis on "immediate help."

Two studies indicated low levels of actual use of community services by patients. Wolkon (446) examined records of, and interviewed, 312 discharged psychiatric patients concerning followup care. Two-thirds did not follow through on the referral; i.e., they did not attend the program more than once. Receipt of government welfare support was associated with greater use of aftercare programs. Serban and Thomas (385) showed that among several hundred psychiatric ex-inpatients, about 40 percent did not use prescribed medication between hospital stays. A similarly large proportion made no use of outpatient service as recommended. Further, nonuse of medication and nonuse of outpatient service and reliance on welfare were positively associated with readmission. Finally a public survey by Sigelman (395) to find a location for a group home indicated that community residents recognized rights of mental patients but at the same time were opposed to having group homes in the community.

In summary, studies of public and patient attitudes toward mental health services indicate an attitude of acceptance of mental illness combined with a rejection of proximity to mentally ill people. Public notions of services for mental illness are centered on obviously deviating behavior and practical services, a different image from that held by professionals.

A second group of six studies were concerned with attitudes of older people toward community services for older people. Dick and Friedsam (103) found that among 95 residents of two homes for the aged, higher morale was correlated with feelings of being helped and with shorter tenure in the home. A survey by Figa-Talamanca (126) of over 1,000 aged people in an Italian community found that over one-third reported themselves in poor health, with chronic or cardiovascular conditions. High morale was associated with good interpersonal relations. Fisch et al. (128) surveyed aged residents of low-rent public housing in New York City and found 12 cases of chronic brain syndrome. The brain syndrome group was less satisfied, was managing poorly, and had very unsatisfactory social relationships. It was speculated that older people with severe brain disorders remained in the community because of their superficial,

strongly independent personalities and inability to tolerate caretaking persons. Henley and Davis (178) interviewed 167 older patients of an urban geriatric clinic. Patients reporting highest satisfaction were those having pleasant relationships in their own household, a preference for living alone, good health, and a feeling they could count on help at home in case of severe illness.

Opinions of tenants in seven housing sites for the elderly were collected by Lawton (236). Medical service was regarded as a necessity, especially by those who had poor health or low morale. Other services were regarded, it seemed, as amenities, in that persons in sites having more services were those who reported needing such service. Sherman (391) from a similar survey drew contrasting conclusions; she believed that responses indicated onsite helps, counseling, and social services made it easier for respondents to cope with their problems and did not reduce their independence.

Four remaining surveys of opinions about helping services held by those needing help concerned handicapped children and medical patients. Brieland (56) followed 41 orthopedically handicapped graduates of a residential school and found that medical and occupational therapy programs were liked best and that vocational, social service, and food programs were liked least. Also, as in the previous survey of residents for homes for aged, children having spent most time in the school were least satisfied. Jones (206) found that mentally retarded students were as satisfied with their school experiences as were other students. Two studies of use and nonuse of health service by those needing health care were reported by Ludwig and Adams (263) and by Ludwig and Gibson (264). The first study indicated that among several hundred users and nonusers of health service, patients of generally lower social status were more cooperative. Females, blacks, unemployed, those referred by social agencies, and those more severely handicapped were more cooperative. In the second study, patients who reported poor health but did not use health service were found to be characterized by low income and high experience with welfare. The urgency of need for care and severity of symptoms were not related to the use of service.

Only five studies were found which dealt with the values and attitudes of families of persons needing help toward the help. Dunlap (109) reported a survey of 275 families who had received help for their disabled children in three rural Alabama counties. As a source of help, public welfare was named by far the most often. The obstacles in getting help most often indicated were transportation and money. Lack of knowledge about service was mentioned by only 4 percent. The interviews also indicated a high level of family closeness and good adjustment among these rural families with developmentally disabled children. Lipton and Suarstad (254) attempted to discover expectations for clinical services held by parents before a visit of their child to a diagnostic clinic. Parents of

all economic and ethnic backgrounds and levels of education held only the most vague ideas about help available. McKinnon (283) found that parents of children in classes for disturbed children, and also the children themselves, viewed the special classes as a positive experience. Warfield (434) interviewed mothers of mentally retarded children who had been in a parent education program. The contribution of the program was felt to be better morale; information about mental retardation was important, the program relieved anxiety, and support came from other mothers in the program. Meyer et al. (290) followed families of retarded children, who had been helped by a clinic team, to discover their opinions of the help. Nonwhite families desired more help for home problems and requested more medication. As to difference between families where mothers did and did not work, more help was wanted where mothers did not work. There was no significant difference between children in families with mother working and not working regarding types or severity of problems. The amount of medical aid requested and the amount of home help needed were *not* related to severity of disability.

Finally, there were six reports concerning the attitude and values of professionals toward service programs or their own part in service programs. Keith (216) sought to determine the congruence between professional preferences among services for the elderly and client preferences for such services. One hundred and twenty-four older black residents of a small midwest city were interviewed, and their responses were compared with responses of about 60 professionals. Both groups ranked legal aid, transportation, and visitation service near the top. Practical assistance in finding housing, home helps, and homemaker health aids were also ranked high by each group. The main difference was that older citizens assigned more importance than professionals to supporting service and maintenance service which would permit older persons to remain in their own homes. Fanshel (119) in a study of 101 foster families found a high degree of satisfaction with the foster mother role. Foster mothers were somewhat more authoritarian in childrearing than a sample of natural mothers. Pincus and Wood (336), in a discussion of problems in measuring the environmental characteristics of the aged, compared staff ratings with resident ratings for one home. The staff saw this residential home as providing more freedom and more resources than did residents. Residents, however, saw the home as less isolated from the community. A large factor in determining resident satisfaction was privacy. Mayer and Rosenblatt (279) compared mental patients' opinions with staff opinions. Patients displayed a more positive assessment of the mental hospital than did any of the staff group. When asked what factors were most important in helping patients to get better, patients gave about equal weight to the five items offered by researchers (eating, talking

about problems, sleeping, medication, keeping busy), while staff consistently rated talking and medication higher than the other three. Psychiatrists rated medication most highly, while psychologists and social workers rated talking most highly. Pappenfort and Kilpatrick (326) interviewed administrators of 95 agencies in Chicago to explore their attitudes and capability to provide programs for physically handicapped children. The results were interpreted as showing that directors of agencies hold inaccurate and stereotyped views about such programs and the problem of beginning such programs. Wilkinson (445) examined acceptance of psychiatric innovations in a large State hospital. More highly integrated treatment teams seemed more capable of accepting innovative programs. Opinions of the head nurse were especially important for other nurses.

CHAPTER 5

SOCIAL POLICY FOR HELPING

Policy discussions were identified for this review if they had relevance to questions around new contexts of helping. These policy discussions included criticism of community-based programs, predictions of future trends, and arguments for more feasible and realistic goals of helping.

Essays, discussions, and research reports relevant to policy are reviewed under six headings. These policy questions were not defined a priori but arose from examination of the reports: realistic goals for helping programs; exclusion of the most handicapped from new contexts; methods of client participation; service delivery mechanisms appropriate to new contexts; coordination between social and health programs; and possible innovations in helping.

Goal Setting: What Objectives Are Reasonable and Appropriate?

Goals for community-based helping programs were of widespread concern. What can community mental health centers accomplish? Can need for help be "prevented?" Will new programs or new contexts of helping lead to change in the entire service system? A total of 19 articles were found, bearing on goals or objectives of new helping efforts, written by Arnhoff (12), Baldwin (19), Bourestom (53), Boyajian (54), Caro (78), Christie (85), Friedson (138), Graziano (160), Hoenig and Hamilton (186), Holden (191), Holland (193), Krause (228), Lowy (260), Menolascino (289), Nathanson (308), Scott (383), Sussman (415), Wagenfeld (428), and Wood (448).

Discussions of goals of new helping efforts for the aged, mentally disturbed, delinquents, and handicapped show several common themes. Sussman (415) summarized changes in the rehabilitation system in the United States: challenge to traditional professional-client relations, inclusion of the family as participants in rehabilitation, and decentralization of service partly to avoid high institu-

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tional costs. Wood (448), in reviewing recent changes in legislation and public attitude concerning addiction, emphasizes the change from a punitive to a helping orientation. Baldwin (19) wrote of the movement for "alternative services" which represents a reaction to traditional professional services and also a greater sensitivity to immediate problems and acceptance for a wider range of deviants. Lowy (260), in setting forth models for organizing new service for the aging, emphasized that local communities must begin the process of setting priorities and must include older persons in this process, since this country does not have adequate general social-planning machinery. Boyajian (54) pointed out striking parallels between the community mental health center movement and the urban mental health movement of 50 years earlier: catchment area planning, emphasis on prevention, participation by community, and improved organization of service in government. Bourestom (53) reviewed literature on major trends in mental health programs for aged. An attempt to review the research on community-based programs was dropped, since so few research reports were discovered. Bourestom found the literature to emphasize importance of physical and external factors in the health of the aged, indicating that comprehensive programs were absolutely necessary. Menolascino (289) proposed a system of adequate services for the retarded and emphasized themes of prevention, advocacy, and active treatment. These pieces concern widely different target groups but may be summarized under four goals: early prevention, decentralized delivery system, active treatment relevant to current problems in which those being helped participate, and a rational system of service delivery to cover all needs.

A number of investigators and commentators have raised questions about prospects for achieving the four goals. Perhaps the most sweeping and carefully crafted criticism of the community-based movement is the critique of community mental health by Arnhoff (12). Arnhoff argued first that the indexes used to express change goals are highly subject to administrative manipulation. Second, he argued that family care has had serious adverse effects on families, including neglect of child care by parents and a sharply increased birth rate among severely mentally disordered. Finally, he stated that community mental health has ignored the existence of a pool of chronically ill patients in the general community who receive little attention. The goal of prevention was questioned by Wagenfeld (428). Wagenfeld attacked the notion that poverty and poor social conditions "cause" mental illness. With respect to changes in traditional treatment, Friedson (138) suggested that depersonalization is a necessary consequence of modern medical care. Nathanson (308) cited a case study, indicating that depersonalization in a community treatment program arose from efforts to maintain a

high volume of attention to community problems; this could be a case where goals of access and quality care have conflicted.

Broader goals of social change and community change were questioned. Holden (191) argued from case study evidence that mental health centers could reduce hospital admissions but not democratize all human services. Four other reports based largely on case studies describe a process of replacing service goals with professional or organizational values. This process of "goal displacement" was illustrated by Graziano (160) with professional bureaucracies joining with parents of autistic children to promote professional goals; by Holland (193) with the American Medical Association capturing most new research funds for the retarded, in the form of new support for established medical research centers; by Christie (85) with conversion of Community Temperance Boards in Norway from neighborly help for drinkers to mechanisms for moralistic propaganda; and by Scott (383) with goal displacement among workshops for the blind over a period of a quarter century from help for the blind to production and business goals.

The question of whether the broad goals of community mental health can be evaluated at all was addressed in several reports. Krause (228) argued for client-oriented indexes and rehabilitation programs rather than interpretation of employment as "success." Caro (78) questioned whether evaluative researchers can operate usefully in changing service programs. Bourestom (53) argued for more "longitudinal and taxonomic" research to establish norms and patterns for long-term care, as a necessary prerequisite to evaluation research. The research report by Hoenig and Hamilton (186) which was done in England was the only report in this review which seemed to exemplify the kind of research for which Bourestom called for.

Target Populations: Are the Chronically Mentally Ill Being Helped?

Will the new programs in the community context actually help severely handicapped people, those who need help most? Will chronic mental patients and delinquents, moving from traditional institutions to new facilities, be better off or worse off? Will community agencies ignore the most needy? These questions were addressed in several essays and research reports by Beigel and Feder (23), Bourestom (53), Butterfield (70), Cumming (97), Hogarty (187), Jones (205), Labreche et al. (230), Lamb (231), Lamb (232), Morris (301), Moss and Lavery (304), Sabagh et al. (366), and Santore and Famond (373). Evidence found in this review indicates that needs of the severely disabled are not being met under the new community-

based programs. The groups most handicapped appear to suffer most from the capture of resources by existing professional and organizational interests for service to more attractive target groups.

A summary of changes in care of the retarded by Butterfield (70) is relevant for the mentally ill, aged, schizophrenic, and physically handicapped, as well as retarded. Population in large State facilities has been reduced dramatically. The facilities themselves have not been eliminated or even reduced in total cost. The State facilities have increased admissions, especially readmissions, along with lower census. There is a "revolving door" effect. Research by Sabagh et al. (366) supported this description for the mentally ill and State hospitals. A review of research on mental health of the aged by Bourestom (53) showed that most mentally ill aged were not in State facilities but were in long-term residential care under some label other than mental illness. The few aged still in mental hospitals received more therapeutic programs. There were not enough reports on community-based facilities to draw any conclusions about service in new contexts.

Cumming (97) in a 1962 essay set forth all of the criticism of the community mental health movement recently leveled by Arnhoff and others. In receiving the six volumes of the Joint Commission on Mental Health and Illness, Cumming criticized those volumes for giving very little attention to the "seriously mentally ill"; for unfounded optimism about community treatment programs given a lack of resources and personnel; and finally for ignoring the tendency of professional and community facilities to prefer easy cases rather than chronic and severely disabled clients. In an equally sweeping but more recent essay, Jones (205) characterized the community mental health centers movement in this country as a political and economic phenomenon, having the function of justifying reduction of mental hospital population through a shift of attention to preventive treatment of younger and more active target groups. Professional, political, and economic forces all conspire against adequate care for "madness, senility, imbecility, and helpless dependency." Jones makes several suggestions for more positive policy initiatives, involving creation of special communities.

The criticisms voiced by Cumming and Jones were supported by research. Hogarty (187), based on his own experience with new programs for schizophrenics, argued that the programs are inadequate for needs of schizophrenic patients in every respect. Labreche et al. (230) supported Hogarty's argument in showing with longitudinal data that discharged schizophrenic patients made little use of outpatient care. Use of outpatient care was significantly less for lower class schizophrenic patients. Lamb (232) followed all chronically mentally ill persons in one community for 18 months. The

more mentally impaired the chronic patient and the longer the period of hospitalization, the less likely was he to establish a normal living situation after discharge. Beigel and Feder (23) found poor utilization of partial hospital services by chronic patients and argued, as did Lamb (231), for carefully designed and probably separate partial hospitalization programs for chronically and acutely mentally disturbed persons. Moss and Lavery (304) also showed misuse and underuse of both health and social services by discharged chronic patients and called for certain practical measures to help them obtain adequate service in the community. Morris (301), in the same vein, argued that personal social service needs of the elderly are not met as well as health needs and that satisfactory community living depends on development of new programs of personal care. Santore and Famond (373) also called for more attention to the needs of aged and chronically ill under community-based programs.

Client Participation: How Can Those Being Helped Have More Control?

Research which has been reviewed in previous sections of this report indicates clearly that programs aimed at positive socialization seem to have more impact where persons being helped can understand clearly the purpose of the program and understand what behavior is expected of them. Apart from issues of "effectiveness," however, there may be a question of human rights involved. A very few items covered in this study address these questions in one way or another. Bolton and Sommer (47) found that first-name address was preferred by physically handicapped patients in a private rehabilitation hospital. Professionals interviewed preferred the formal mode of address. The authors suggested use of first names as a way to democratize helping. A report by Friedman (137) described the use of elderly resident volunteers to welcome and help new residents to adjust to the institution. Group members were able to help each other express negative feelings about rejection by family members, about the nature of the institution, and about the experience of dying. In that program it would seem that client participation was a mutual helping experience and not a cooptation of clients into a helping program. A study by Ellsworth and others (114), reviewed in chapter 1, showed that psychiatric units where patients had a low rate of return were characterized by both motivated professional staff and active participant role for patients. Client control of resources was not considered in any of the studies.

Service Delivery: How Can Help Be Organized In New Contexts?

Policies of "purchase of care" and "decentralization" were touched on in reports by Bell (27), Butler (69), Hacker and Gaetz (171), Jansen (199), Kistin and Morris (222), Lerman (243), Lerman (244), Ohlin et al. (317), Schulberg (380), Silverman and Val (397), Slickney and Cupaiuolo (401), and Truax et al. (422). Several reports examined "purchase of care" policies, i.e., a local or regional authority using funds to purchase services for specified target groups. The supposed advantages are greater efficiency, more local participation by clients and others, and easier change in service systems. Butler (69) made a case against purchase of nursing home care for the aged. He argued that better care might result from "social utilities" which would be community-based semi-public corporations. Bell (27) argued that designation of a single public agency or local authority in a given area to organize, fund, and coordinate all services for aged at home would prevent or delay institutionalization. Kistin and Morris (222) used the term "personal care organization" to designate a quasi-public corporation to contract with State departments for comprehensive care and service to the elderly and handicapped at home. Schulberg (380) suggested using unneeded mental hospitals as comprehensive community oriented "human services resource centers." The centers would be semi-public corporations selling their services to public authorities. Ohlin et al. (317), in a preliminary report of the drive to deinstitutionalize services to youth in Massachusetts, predicted that the program would be successful. The new program basically involved regional authorities who made case decisions on delinquent youth and also authorized and coordinated services. In other words, responsibility and authority were pulled together from several centers to one center. Lerman (243, 244) described failure of two community-oriented organizational change projects in California. Lerman's argument supported the purchase of service approach, since his study like many others documents the inability of government planners to eliminate large public facilities even when no longer in use. Reports by Slickney and Cupaiuolo (401) and by Jansen (199) describe two variants on another organizational approach—the creation of new associations or organizations on a quasi-public basis, which helped to develop new local programs.

Decentralization of service delivery also was studied as a means to achieve greater public participation and better coverage. Silverman and Val (397) described sharing of power or reciprocal control in a day hospital where intake was controlled by mental health center outpost workers in the community rather than by the day

hospital staff. Hacker and Gaetz (171) describe interdisciplinary health team operations in a psychiatric facility for the aged. The hypothesis of greater client understanding and information under team operation was not supported, but the team approach did seem to introduce more alternatives in planning. Whittington and Steenbarger (442) studied decentralization of a psychiatric team based in a hospital in the community it served. It was observed that after decentralization there was more active service utilization by patients.

Coordinating Programs: How Can Health Care and Social Care Be Combined?

The familiar problem of coordination received considerable attention in research reports and essays written by Ahmed and Young (4), Bergman (36), Berkman and Rehr (37), Brendes (57), Clark (87), Curtis and Miller (98), Guttmann and Miller (170), Holden (192), Kavaler and Swire (214), Lebowitz and Dobra (240), Lerner and Blackwell (245), Linstrom et al. (252), Maholick (269), Mishara et al. (296), Piedmont (333), Rogoawski and Edmundson (360), Sauber (377), and Treger et al. (421). The main argument for better coordination seemed to be that more comprehensive coverage of community needs and better attention to situations of persons needing help could be achieved by it. A strong central theme was need to combine medical and social services for one individual.

Problems of combining health and social services were explained in a number of reports. Bergman (36) followed 606 elderly persons who signed themselves out of a group of private homes for the aged. After 10 years only one-tenth of the 606 had returned to the institutions. Of those who had returned, the primary reason for return was deterioration of health and unavailability of medical service in the community. Sauber (377) described a similar situation with respect to the necessity of children going into foster care. Interviews with over 400 families indicated that the primary reasons for placement were health problems of parents or children. Physical illness or incapacity of the child caring person accounted for 29 percent of the cases, while mental illness of the mother and personality problems of the child together accounted for another 28 percent. Sauber concluded that better community services for children in their own homes were needed. Ahmed and Young (4) described a program where public health nurses acted as brokers or bridges between hospital or institutional community settings to keep ex-patients out of the mental hospital. Guttmann and Miller (170) reported a survey of senior citizen centers showing that among 70 large centers, over one-third did not provide health service. The authors raised ques-

tions as to whether the centers served any important purpose. Berkman and Rehr (37) studied referral of elderly patients to social service in a New York medical center. Most patients were referred during the final phase of hospitalization, just before discharge. Effective social and health planning would be possible only, the authors argued, with earlier referrals. Kavaler and Swire (214) found children in foster care in New York City, who needed medical service, were subject to many bureaucratic and organizational obstacles. Lerner and Blackwell (245) found in interviewing over 100 psychiatric inpatients that family doctors were not important resources for treatment. One reason for failure to involve family doctors in social and health planning for the chronically ill may have been revealed in a study by Piedmont (333). General practitioners in St. Louis, and clergymen as well, tended not to refer to psychiatrists when they received few reports on their clients. Maholick (269) described a system to bridge scarce professional services and community situations, the same problem addressed by Ahmed and Young (4). A number of reports illustrated different methods to achieve better coordination, especially between health and social services. Clark (87) described a transfer office within a large general hospital to facilitate community placement. Linstrom et al. (252) reported on placement of a social worker in a private doctor's office to promote social-medical collaboration. The facilitation of geriatric transfer from mental hospital to nursing home by sending nursing staff along with patients for 1 month was described by Mishara et al. (296). According to research reported by Rogoawski and Edmundson (360), referrals from inpatient to community services were more often completed when the referring professional had more interest and was more active in referral. Various coordination problems and devices were analyzed in terms of police-social work relations by Treger et al. (421); for interstate probation and parole by Brendes (57); for recreation programs for the elderly by Curtis and Miller (98); for short-term psychiatric care in a general hospital by Holden (192); and for Social Security interviewer referral to community agencies by Lebowitz and Dobra (240).

Future Developments: What New Forms of Help Are Needed?

New ways to help, in new contexts, were suggested by Bell and Olsen (28), Brostoff et al. (63), Burt and Balyeat (68), Colter (93), Greenberg (161), O'Rourke and Salem (319), Shyne et al. (394), Spivak (406), White and Beattie (439), Wooden (450), and Zalba (452). With respect to the aged, Brostoff et al. (63) described a project to relate police and social service in protection of the aged.

Bell and Olsen (28) argued that experience with special transportation for the aged has shown that systems combining demand-responsive facilities with fixed transportation routes are emerging as most practicable. Carey (77) described an outreach social service program in public housing for the aged. Tobin (420) projected future trends in service for the aged with primary emphasis on "hospice" service to permit the experience of terminal illness and death with more dignity and comfort.

Shyne et al. (394) suggested methods for reducing long-term foster care. Wooden (450), at the end of a lengthy indictment of long-term care of youth in the United States, sought to put together a profile of successful and humane child care programs. Characteristics included several factors such as intake policy and treatment emphasis which could be converted into widespread policy suggestions. Burt and Balyeat (68) described a comprehensive emergency program which helped to place children.

Spivak (406) outlined a framework for housing of discharged psychiatric patients in which he attempted to combine social and physical needs. White and Beattie (439) suggested that institutionalization of the severely retarded might be reduced by more training and support of parents.

With respect to legal offenders, a number of policy initiatives might be noted: physical subsidy for discharged offenders as proposed by Colter (93); a voucher system to permit offenders to purchase their own rehabilitation services as proposed by Greenberg (161); an independent bail agency under public auspices which encourages "release on own recognizance" by O'Rourke and Salem (319); and early release for prisoners who have jobs by Zalba (452).

CHAPTER 6

SUMMARY AND DISCUSSION OF FINDINGS

This review was at once disappointing and exciting. The review was disappointing in that there was little serious work on social contexts for helping those who are unable to provide for themselves. Among helping professionals, interest is primarily limited to case studies of the acutely or dramatically disordered rather than the chronically handicapped who need continued help. Among social scientists there is little concern for study of helping contexts for any of the needy populations. Yet this review was exciting in that there were many clues to possible directions for future work.

The bringing together of several areas of knowledge about contexts for helping, and several different target groups, made it difficult to summarize this review. But the broad coverage was valuable in that reinforcing insights were gained from different work. There is no attempt to summarize and analyze all the bodies of work cataloged in the review. This chapter should not be viewed as representing replicable conclusions from a research study; rather it represents the assessment and personal conclusions of a social scientist who has read several thousand pages on "contexts for helping."

New Contexts and New Ideas for Helping

Alternative contexts for helping those unable to care for themselves were limited only by human imagination. Supervised apartments, foster family homes, transitional houses owned by community corporations, converted motels, welfare hotels, own homes, sheltered workshops, and many other helping situations were described in the 455 reports included here. Despite the wide variety, it was clear that new contexts of help could be adequately summed up under three headings:

- community-based residential facility
- daycare center
- home of person needing help

The typical organizational and program structures of these settings, insofar as they could be determined from this survey, are summarized in the second section of chapter 1. The emerging picture of alternative care is proliferation without planning and without the imposition of standards.

This survey turned up two censuses of halfway houses. Aside from these two government-sponsored surveys of halfway houses, factual information is lacking. The professional and scientific literature gave no basis for estimating numbers of staff and clients involved in different settings.

It is important to distinguish the small community residences oriented to maintenance from these oriented to development and change. Most maintenance-oriented and community-based residential facilities, as portrayed in the literature, were targeted on mentally ill or alcoholic persons. These facilities appeared in most cases to have been created to substitute for State hospitals. Programs appeared largely custodial. It was usually intended that residents move out in 6 months or a year, but many did not do so. The one clear difference from State institution residence was access to employers, social agencies, and community health or recreation services.

Dynamic programs oriented to change were exhibited in a few reports. The small residence was used as a focus for development and change in lives of retarded, delinquent, and disturbed adults and children. These scattered reports are discussed extensively below and in chapter 1.

Daycare centers, as described in the literature, were designed to supplement personal living arrangements and prevent institutionalization. The day-center category included activity centers, social skill training, sheltered workshops, special classrooms, and partial-day hospitalization. No systematic surveys were found. A main dimension of variance seemed to be social activity or training versus nursing and medical care. Program emphasis appeared to be on one end of this continuum or the other.

Home-delivered services were the subject of many intriguing and diverse reports. Meals, physical examinations, friendly visiting, chore service, counseling, organizational efforts, and many other services were home delivered.

This survey then identified three emerging alternative social contexts of help. Alternative helping situations and programs, as described in the literature, are grouped and summarized in the second section of chapter 1. The research up to mid-1976 was not systematic or substantial enough to permit either a descriptive

overview, on one hand, or analytic generalizations about social structure of these settings, on the other hand. New concepts of helping situations and interesting program ideas (below) came from this survey. The literature did not answer the elementary descriptive question of what social organizations are used to help those unable to provide for themselves.

While the literature was weak on the social demography of alternative helping situations, it was rich in new techniques and social arrangements for helping. In the following pages, several new ideas are noted: "social development services," "absorbing situations," and others. But at this point, a sampling of other specific and isolated suggestions is offered. These suggestions go beyond the new social situations noted above yet seem logical and necessary extensions of the "alternative to institutionalization" movement.

A "hospice" service—a temporary care center to permit terminal illness and death in comfort with normal social supports—was suggested by Tobin (420). The theme of maximizing normal social supports runs through a number of other futurist suggestions. Jones (205) speculates that a village or community of chronic dependents for long-term care would encourage ties of dependency and loyalty. Training of parents for better handling of children is another suggestion in the same vein. The idea appears several times in this review in connection with mentally retarded children (e.g., 234, 374, 439). But the same idea was suggested for families of delinquents (7), learning disabled (140), and disturbed (89). Simmons et al. (398) reported a project carrying the notion of family participation to the point of a Family Resource Center where whole families could live temporarily.

New ideas for service delivery, i.e., financing and organization of a service system, were also scattered through the literature. The theme of creating incentives for desired outcomes appeared several times. So-called "psychopathic delinquent" youth were rewarded for social behavior (197). Drug addicts were employed as social service workers primarily to see if their lifestyle would change with regular adequate income and a job (67). Other authors suggested different mechanisms than personal incentives to improve quality of care. Several authorities believed public and client sharing of control to be significant. Butler (69) charged that private purchase of nursing home care has had perverse effects. He, like Schulberg (380) and Kistin and Morris (222), suggested some form of social utility or quasi-public corporation to contract with State agencies and provide local comprehensive care to aged. Bell (27) suggested a local authority for planning and monitoring of service to aged, and Ohlin et al. (317) supported such a development in the Massachusetts youth program.

Adequate responsive emergency service was a suggestion of many

authors; it was thought that timely help might avert institutionalization. Proposals and preliminary trials, too numerous to review here, were offered for alcoholics, the mentally ill, children at risk, and other groups. At the other extreme from emergency service was a theme found at least a dozen times: Needs of those chronically needing help should be differentiated from temporary needs. Lamb (231) and Beigel and Feder (23) argue for separate services for acutely and chronically mentally disturbed. Neglect of needs of chronic schizophrenics and other target groups was documented by many authors. Perhaps new facilities and even new professional specialties are required to meet needs of those chronically unable to provide for themselves.

Methods and Goals of Effective Helping

Helping activities themselves will be considered before going on to consider what is known about social contexts for helping. The basic purpose of this review is to place the helping activity in its social situation; but still it is well to sort out what has been demonstrated about the consequences of different sorts of helping activity.

A major and unexpected finding from this survey of the literature was that standard forms of therapy delivered by professionally qualified professionals demonstrated few positive results (3, 9, 38, 46, 72, 86, 100, 107, 180, 188, 189, 190, 202, 203, 204, 224, 243, 325, 392, 422). These findings are reviewed in chapter 2. "Standard forms of therapy" mean drug therapy, group and individual psychotherapy, street work, and social case work. As noted in chapter 2, drug therapy for management of schizophrenics outside of State hospitals was the only form of therapy which figured more often in positive than in negative results.

Several qualifying comments should immediately be added to this observation. First, this review was focused on providing care and help for those unable to provide help for themselves—in other words, on long-term care populations. The research reviewed here may be an unrepresentative sample, since only the most difficult target groups are included. Nevertheless, there are indications that more practical and narrowly focused forms of help are effective, even with these difficult target groups.

A second objection which might be made to a finding that treatment is not effective is that "everyone knew that already." There have been a number of reviews of psychotherapy, social casework, and clinical psychology with sweeping negative conclusions. There is little value in adding another to a long list of emperor-has-no-clothes reviews. It is worthwhile, however, to investigate possible explanations for the repeated negative finding. The breadth of this

review made it possible to identify certain factors which may explain the negative findings and may help to focus future work.

A positive suggestion for future work on effective helping arises from the research reviewed in chapter 2. Programs of training, social activity, and humane care were effective in maintaining those unable to provide for themselves outside of institutions, in improving their role performance skills, and in improving their quality of life (29, 60, 67, 81, 116, 154, 169, 176, 197, 271, 306, 312, 339, 342, 349, 369, 423). Research and evaluation reports in this group exhibited a combination of social-development orientation to social situations and modest outcome criteria.

Evaluation studies concerning training and self-care, development of interpersonal skills, and provision of practical services were reviewed in some detail in chapter 2. Few of the research reports entailed the controls and precise observations required for adequate proof. Nevertheless, positive outcomes claimed for many of these programs seemed plausible. Further attention should be paid to this line of development.

Further exploration of possible bases for positive outcomes is indicated. These programs of training and practical help for many different target groups have in common the improvement of social performance of those who need help or the improvement of their social situation. The term "social development" seems an appropriate one to summarize this approach to help.

Three features of a social-development approach were noted: (1) a clear focus on specific role performance of those who need help, or sometimes specific features of the social environment which should be improved; (2) the giving of help more often by nonprofessionals than by highly qualified professionals; and (3) a definition of modest and immediate goals of change. Each of these features of the helping method, termed here "social development," deserves further comment.

Interpersonal or social skills which were the focus of help included such role performance abilities as initiating conversation with others, continuing social interaction in the face of mild hostility, performing daily household chores, and finding one's way about a city on the bus system. But many of the programs, as noted above, were not focused on role performance of those who need help. Many of the programs were focused on the situation or the context for help. Some programs sought to produce a more cheerful residential environment, while many others sought to increase social interaction between caretakers and clients or meaningful social conversation about current events among those who need help in a residential setting.

Help meant exclusion of vague psychosocial change goals as well as inclusion of specific goals. The idea of "humane care" rather than

"treatment" was advanced with respect to incarceration of delinquents by Perrow (329), as noted in chapter 2. The ideology of "humane care" included the notions that whereas "treatment" assumed a desire and attempt on the part of the juvenile to change his life adjustment, "humane care" makes no such assumption. The provision of humane care is to create a situation in which the juvenile himself may choose either to maintain, or alternatively to change, his social role behaviors.

The fact that programs of social development were most often administered by nonprofessionals seems important. There was not enough information in the reports about the helpers to permit analysis differences in professional preparation. It was clear that few professionally qualified helpers were involved in social development programs. Perhaps professionally qualified therapists eschew social development methods as too simplistic. Alternatively, it might have been the case that program sponsors opted for practical services by nonprofessionals because they could not afford or could not obtain professional helpers. This question certainly deserves more attention in future descriptive studies.

Goals of helping programs should be examined. Evaluations of social development programs were more often positive than evaluations of conventional helping, but usually social development programs had more modest goals. Did the positive results occur because goals were "easy?" That is impossible to say without further research. It can be said, however, that most evaluation research discovered in this survey used goals of social performance, whether the programs were conventional clinical treatment techniques or social development. Of some 140 evaluation reports found in this survey, without regard for completeness of the reporting or quality of the research, the following tabulation shows the main outcome variables used:

Chronicity; staying out of care	45
Vocational or school performance	34
Other social role performance	26
Social interaction, social relations	22
Satisfaction, positive attitudes	17

This tabulation does not support the argument that programs of social development appeared more successful because they had *easier* outcome variables. It is the impression of the reviewer that programs of social development had more narrowly defined social performance criteria. In general, however, both groups of program evaluations had similar outcome variables.

Implications for goal definition in future evaluative research seem clear. Consensual definitions of social development programs of help are needed. Widespread use of a few reliable indicators of

chronicity and social performance would be most helpful and would permit comparison of different treatments. The outcome measures widely used in the studies reviewed here—staying out of the mental hospital, amount of treatment or help needed, adequate vocational or social performance—may have been adopted because chronically handicapped long-term care populations are concerned. These outcome indicators do have high reliability and seem clearly related to the main concerns of social policy formation.

Research on effective helping is costly, judging from this review. Design of evaluative research needs to recognize that 3 to 5 years are required for conceptualization, program formation, and adequate observation. Use of nontreated control groups is usually not acceptable. A solution frequently found in this review was to use different treatments which are roughly equivalent in cost. Use and monitoring of several treatments are, again, expensive. Adequate monitoring of experimental procedures is difficult. Details of program provision, cost of treatment, and details of outcome data were inadequately reported in most of the evaluation studies found in this survey. Considering the large social investment made in trying out new programs during the 1960s and early 1970s, it is regrettable that more systematic research studies were not carried out. In a time of public resistance to social programs, ingenuity is required to build experiments into ongoing operations.

Design of New Social Contexts for Help

The next topic in this summary and discussion is the question of whether new contexts for helping, as against methods for helping, have proven to be effective. Are methods of help independent of the situation? Can context change outcome?

The terms of this problem need definition. First, it must be specified that caring for those unable to provide for themselves in a smaller setting, or in a setting near their home, is not in itself a guarantee of effectiveness. When mentally retarded residents of a State training school were moved to New York City in the Gatewood project (43), as noted in chapter 1, the institutional nature of the State training school was recreated. Yet the State training school staff had not come with the residents. Apparently the residents simply "trained" the new staff members in accustomed role relationships. Other descriptive surveys of community programs covered in this review made it clear that depersonalization and neglect of social and physical needs can occur as readily in the community as in the institution (23, 53, 70, 230, 231, 232). Family foster care for chronically mentally disabled persons may produce a quality of life no better than that of typical large institutions.

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If it is possible to recreate an institutionalized situation in the community, is the converse true? Is it possible to change the institutional setting and create a new context for living in the middle of a traditional institution? The first section of chapter 1 gave several examples of efforts to do exactly that. Evidently, some of the projects were successful. The most successful exhibited the same characteristics as the "absorbing situation" described in the latter part of chapter 1 and analyzed below.

The main lead to emerge from this review on effect of contexts is the notion of the "absorbing situation." The term "absorbing situation" was used to summarize the characteristics of several residential helping projects which were reported as being effective (16, 20, 22, 43, 83, 118, 277, 293, 302, 409). At this point, it would be useful to speculate further on social characteristics of these absorbing situations.

The target groups served in each of these 10 projects were severely, not marginally, socially deviant. Problems included mental deficiency, psychosis, and well-established juvenile delinquency. The residents were thus severely handicapped in terms of normal role performance and furthermore were at a transition point or crisis point in their lives.

A second point, common to all of the 10 program experiments, was a high demand for role performance. The performances and behaviors expected of residents seemed very clear in each case. Performance included such diverse items as grooming of self, prompt performance of household chores, and so on. Given that the residents in each case were severely retarded, had been diagnosed as schizophrenic, or were found guilty of repeated delinquencies, it is fair to term these expectations as creating a "high demand" situation.

If these absorbing situations exacted high demands on their residents, they also offered their residents a high degree of support for performance. In at least half of the projects, it was clear that the staff-resident ratio was about one to one. In a number of the projects the staff members lived in the same situation with those unable to provide for themselves. Length of residence of clients was commonly 1 to 2 years. A fully planned daily schedule was provided. In program descriptions there were frequent terms suggesting close interaction between residents and staff; for example, "nurturant nursing," "highly structured program," "close supervision." In short, the lives of those being helped by these programs were full. There was not time for vacant hours spent sitting in a day room, watching television, or wandering about the grounds.

As a concomitant of clear specific roles and close programing, role achievement by those being helped was closely monitored, and adjustments were made in the helping program. In some projects

the goal setting and monitoring were carried out in a framework of reinforcement theory. Regardless of theoretical base, each of the 10 programs had in common closely supportive supervision; it was impossible for residents to continue living in any of the programs with no recognition of whether desired goals were being achieved.

A final noteworthy feature of the 10 absorbing situations was absence of conventional helping techniques. Individual and group psychotherapy, drug therapy, and casework or other counseling were played down or were absent. The staff in all of these helping situations appeared to be qualified by special training for the project, not by extensive formal education.

In summary, the creation of closely monitored and thoroughly programed "absorbing situations" appears to be a way in which severely handicapped people can develop new role performance and enjoy a significantly higher quality of life. No claim is made that this is a promising solution for care and improvement of the hundreds of thousands of people in the United States unable to provide for themselves. Cost level of these programs, though usually not reported, appears to be approximately equal to residence in a skilled nursing facility. At present, society is not committing the necessary resources to support such settings on a widespread basis. Furthermore, the professional leadership to operate such programs is probably not available. The significance of this group of projects, however, lies in the fact that society as well as helping professionals has tended to sweep under the carpet the severely handicapped target groups who were successfully helped in these projects. Further analysis and experimentation might indicate the key factors present in successful projects, which can be transferred more widely to helping efforts.

The Social Process of Resocialization

The social science concept most likely to connect social theory to effective helping through "social development" programs is the concept of socialization. Among social scientists, "socialization" generally means the process of creating a social being. Acquisition of language, cultural values, the capability to sustain close personal relations, and a wider range of role performances are all encompassed by the term "socialization." Most social psychologists would agree that successful socialization is a property of the situation and the social system and not simply a property of the human individual. In other words, some families, communities, and schools provide conditions for effective and successful socialization, while others do not.

There is a close connection between design of social development

on the cognitive, affective, and social functioning of senile patients in a geriatric institution. It is hypothesized that institutional conditions of isolation and stimulus deprivation accelerate the deterioration of the very old patient. Provision of a more intense and diversified social, psychological, and physical environment would therefore result in a partial remission of the degenerative processes. The study took place on comparable all-male wards at the Daughters of Jacob Geriatric Center in the Bronx. One of these wards was the experimental group; the other served as a control group. All experimentals and controls were Jewish with Eastern European backgrounds and similar physical and emotional conditions. The physical environment was anonymous and bland, while the recreational/occupational activities were limited. More intense and varied stimulation was sought for the experimental group. The ward was redecorated. Efforts were made to stimulate the patients' cognitive resources and emotional response, e.g., a bedside sheltered workshop program, bedside visiting by hired visitors, and toilet retraining for incontinent patients. Net increase in activity and stimulation received by each patient in the experimental ward ranged from 1 to 3 hours per weekday. Though there was a trend in the positive direction for the experimental group in cognitive functions, there was no significant improvement over the control group. The experimental group exhibited significantly greater psychopathology. This was believed to be a reflection of the increased activity and awareness of the patients, who became more critical and demanding. The Energy Scale indicated a general increment in the motivational level of the experimental ward as a function of increased sensory input. Patients became more active in their involvement with the social and physical world. Intensified sensory input results in increased affective states and stimulates social behavior. To be avoided for the very old patient are routinization, depersonalization, blandness, sterility, and infantalization. Instead, a variety of meaningful inputs are needed. (17 references)

257. Lorei, Theodore. Prediction of community stay and employment for released psychiatric patients. *Journal of Consulting and Clinical Psychology*, 31(4): 349–357, 1967.

Reported is a study of 215 male veteran ex-mental patients to identify patient and relative characteristics that are related to release outcomes. Median time spent in psychiatric hospitals was 26.4 months, and median hospitalization just prior to release was 9.2 months. Of the patients, 77 percent were schizophrenic and 17 percent psychoneurotic. Data came from Veterans Administration records, questionnaires administered

to patients, questionnaires mailed to relatives, and patient rating scale by social workers. The two primary outcome criteria were the number of days during the first year the patient spent continuously in the community without interruption by hospitalization and whether or not the patient was employed full time for at least 6 months. Of the 215 patients, 83 (39 percent) returned to the hospital during the first year, and 52 (24 percent) worked full time for at least 6 months. Success in remaining in the community is associated with not being hospitalized in the 2 years prior to the most recent admission, not having a drinking problem, not "professing disability," reporting a feeling of "well being," disagreeing with items expressing "negative evaluation of family" and "alienation," and being rated low on "manifest psychoticism" and high on "emotional stability." Success in obtaining and holding a full-time job for at least 6 months was associated with being white, married, having been in the hospital a small percentage of adult life, not having been hospitalized in the 2 years prior to most recent admission, having a recent job, not "professing disability," not being "uncritically optimistic," not "expecting special consideration," not having a negative evaluation of family life, and being rated low on "manifest psychoticism" and high on "competence." Factor analysis identified six factors that accounted for 44 percent of the total variance. The patient who was high on distress/alienation, on drinking/antisocial behavior and whose relative is high on patient depreciation tended to have a short stay in the community. The patient who was high on chronicity/severity of disorder and simple-mindedness tended not to work.

258. Lorei, Theodore W., and Gurel, Lee. Use of biographical inventory to predict schizophrenics' posthospital employment and readmission. *Journal of Consulting and Clinical Psychology*, 38(2): 238-243, 1972.

Results are reported from analysis of the Palo Alto Social Background Inventory (PASBI) individually administered to 720 patients just prior to release from nine VA hospitals. Selection criteria limited the sample to males under the age of 60 with diagnoses of schizophrenia. After each patient was out of the hospital for 9 months, followup interviews were conducted by research social workers with the patient and with a family member and/or other informants. Among other things, information was gathered regarding employment and any readmission for psychiatric treatment, the latter being defined as 15 consecutive nights on a psychiatric ward. Internal analysis of PASBI resulted in a 10-factor set being chosen as the preferred solution: a perception of disability factor, a marital affiliation factor, an alienation factor, a chronicity factor,

an education factor, an uncritical optimism factor, a social isolation factor, an irregular employment factor, a drinking problem factor, and a socioeconomic factor. The 10-factor scales were entered as independent variables into step-wise multiple-regression analysis with total work and readmission as dependent variables. The multiple correlation for total work was .39 ($p < .01$) and for readmissions was .11 (NS). Patients most likely to work following hospitalization were those who were married, who reported least prior hospitalization, who saw themselves as least disabled and vocationally handicapped, and who were more regularly employed in the past. In the regression analysis, however, once five of the factors were entered, the combined effect of the remaining five factors resulted in accounting for only an additional 1 percent of the variance. The PASBI-readmission correlations shed practically no light on why many patients (33 percent) were readmitted.

259. Lorei, Theodore W., and Gurel, Lee. Demographic characteristics as predictors of posthospital employment and readmission. *Journal of Consulting and Clinical Psychology*, 40(3): 426–430, 1973.

Data on 20 demographic characteristics of 957 schizophrenic patients discharged from 12 VA hospitals are analyzed in relation to readmission and work. They were predominantly unmarried, had been hospitalized for an average total of almost 4 years, and had worked less than one-third of the 5 years preceding release. Correlational analyses were performed on the 20 demogaphic variables and number of weeks of employment and "readmission" during the 9 months following release from the hospital. Readmission is defined as a return for psychiatric treatment involving a minimum of 15 consecutive nights on a psychiatric ward. Fifty percent of the sample did not work at all. Thirty-three percent were readmitted. Failure to work and readmission were correlated .20, a small but statistically significant ($p < .01$) relationship. The best predictor of amount of work in followup period was the months of full-time work in the 5 years prior to release; the best predictor of return to the hospital was the number of times that the patient had been in the hospital before. The patient who worked less in the followup period tended to be older, nonwhite, unmarried, to have less education, to have had a longer period of hospitalization, to have had more frequent and more lengthy hospitalization in the past, to have received more compensation, etc. The patient who was readmitted tended to have been hospitalized more frequently in the past, to have spent more of his life in psychiatric hospitals, to

have had more trouble with the law, to have had pre-release work experience, and not to have possessed a valid driver's license. The multiple correlation resulting from using all 20 demographic characteristics for predicting weeks of work was .52. However, a computer-selected set of five variables (months of full-time work in last 5 years, amount of compensation, trouble with law, age, and a valid driver's license) yielded a multiple correlation of .50. A computer-selected set of two variables (number of prior psychiatric hospitalizations and problem with alcohol) yielded a multiple correlation of .17 with readmission. Both of these multiple correlations are statistically significant.

260. Lowy, Louis, Models for organization of services to the aging. *International Journal of Aging and Human Development*, 1(1): 21-36, 1970.

261. Lubin, Bernard; Hornstro, Robijn, K.; Lewis, Ruth V.; and Bechtel, Beverly S. Correlates of initial treatment assignment in a community mental health center. *Archives of General Psychiatry*, 29(10): 497-500, 1973.

262. Lubow, Bart K.; Kimberly, Robert P.; Button, William H.; and Kimberly, John R. An empirical approach to work behavior, interaction, and rehabilitation. *Human Organization*, 28(4): 303-321, 1969.

263. Ludwig, Edward, and Adams, Shirley Davidson. Patient cooperation in a rehabilitation center. Assumption of the client role. *Journal of Health and Social Behavior*, 9(4): 328-336, 1968.

A report on physical rehabilitation of patients who fail to cooperate in a medical regimen or who leave the treatment situation prematurely is presented within the framework of role theory. A population (406) of predominately white, male, middle-aged individuals using inpatient services at a large university-affiliated hospital during 1957-1961 were divided into two groups: those who had cooperated and completed services, and those who had not. The role characteristics and social positions of the two groups were compared. Contingency analysis indicated that females ($p < .05$), blacks ($p < .05$), and unemployed ($p < .001$) were more cooperative and more often completed their programs. Further, those referred by or sponsored by agencies with the exception of workmen's compensation ($p < .01$) and those more severely handicapped ($p < .001$) were found more likely to cooperate in and complete their rehabilitation program.

264. Ludwig, Edward G., and Gibson, Geoffrey. Self-perception of sickness and the seeking of medical care. *Journal of Health and Social Behavior*, 10(2): 125-133, 1969.

265. Luger, Milton. Innovations in the treatment of juvenile offenders. *Annals of the American Academy of Political and Social Science*, 381: 60-70, 1969.

266. Lundman, Richard J.; McFarlane, Paul T.; and Scarpitte, Frank R. Delinquency prevention: A description and assessment of projects reported in the professional literature. *Crime and Delinquency*, 22(3): 297-308, 1976.

Based on a search of the professional literature, data on delinquency prevention are described. It appeared unlikely that any of the projects prevented delinquency. Of the many citations, only 25 studies were found to contain information on the nature and results of the prevention project. All of the projects examined involved attempts to correct the presumed causes of delinquency. "Prevention" involved some type of interaction between the juvenile subject and an adult change agent, or alteration of the school environment, or recreation, or provision of employment opportunities, or diversion. The youths involved in these efforts were usually inner-city, working—or lower—class, minority, and male. As a result of poor research design, subjective evaluation, and reliance upon empirically unsupported assumptions, the majority of these reports did not permit reliable assessment of results. In the few projects where design and measurement techniques permit more reliable assessment of results, it became clear that there were no differences between experimental and control groups. Next steps might be direct field observation of delinquents, construction of integrated theories which reflect these field data, and assessment of the constraints which currently compromise prevention efforts. (44 references)

267. Lurie, Abraham, and Ron, Harold. Family-centered aftercare for young adults. *Hospital and Community Psychiatry*, 27(8): 36-38, 1970.

268. Maas, Henry S. Children in long-term foster care. *Child Welfare*, 48(6): 321-333, 1969.

Findings in a followup study of children in foster care for 10 or more years are analyzed to determine the factors and conditions that differentiate such children from others in foster care. The study covered 422 children who, in 1957, were in foster care under the auspices of 37 agencies and 8 counties across the Nation. Of the 422 children, 31 percent were in foster care 10 years or more, while 52 percent were in foster care 6 years or more. Detailed data offered on sex, age at separation, judgments on mental health, precipitating causes for separation from parents, and the nature of the separation showed no differences between long-term and short-term fos-

ter children. Long-term foster children were distinguishable in terms of lower socioeconomic status, below average intelligence, irremediable physical disabilities, and poor parent-child relationships. The association between length of time in care and final disposition of the child proved to be the strongest association. The longer the child remains in foster care, the less likely he is to be adopted or, after the first 5 years, to return home. This study indicated a need for the kinds of child welfare programs that increase visibility of both the child and his parents and that aim to compensate through special services for the child's deprivation prior to and during his long-term foster care.

269. Maholick, Leonard T. A delivery system for local mental health services. *American Journal of Public Health*, 62(3): 364-369, 1972.

270. Maisel, Robert. The ex-mental patient and rehospitalization: Some research findings. *Social Problems*, 15(1): 18-24, 1967.

Presented are reasons for rehospitalization of ex-mental patients based on interviews with 60 ex-patients who had been discharged from 1950 to 1960, and their families. This report is based on preliminary analysis of data from the Hollingshead-Myers study to follow discharged mental patients. All ex-patients meeting study criteria were included. For patients whose behavior could be rated as appearing normal or abnormal, 28 percent of the "abnormals" were rehospitalized in the first year as compared to 14 percent of the "normals." In the first year following discharge, 89 percent of the working ex-patients remained in the community compared to 48 percent of the nonworking ex-patients. Further statistical analysis demonstrated that the large difference in rehospitalization, favoring those who were working, was not accounted for by family support or by normal appearance of behavior.

271. Maley, Roger F.; Feldman, Garry L.; and Ruskin, Robert S. Evaluation of patient improvement in a token economy treatment program. *Journal of Abnormal Psychology*, 82(1): 141-144, 1973.

The improvements in the behavior of chronic mental patients in a token economy treatment ward are compared with control group patients who received typical custodial treatment. Female mental patients diagnosed as chronic schizophrenics were randomly assigned to experimental and control groups, 20 to each. The experimental program included a token economy system which specified the consequences of various behaviors in terms of both positive and negative reinforcers and also individual treatment work and group treat-

ment. Interviews were conducted at 6 months to measure patient capacities in terms of orientation, spending, discrimination, command and timed walk. Statistical analyses of the interview data indicated that the token economy subjects were better oriented, had more skill in making business purchases and discriminations, and were better able to follow commands. Analyses of ratings of video-taped interviews indicated that token economy subjects were rated as being more cooperative and communicative, more socially desirable, more appropriate in mood, and as exhibiting less psychosis.

272. Mannino,. Fortune, and Shore, Milton F. Family structure, aftercare and post-hospital adjustment. *American Journal of Orthopsychiatry*, 44(1): 76–85, 1974.

A study of post-hospital adjustment of former mental patients is presented. Former patients who participated in an aftercare program for at least a year after discharge and former ex-patients who were not in the aftercare program were compared. Former patients were interviewed to determine family situation, current professional help, free-time activities, and a social adequacy rating. Control group and aftercare group showed only one significant difference—that of greater involvement in free-time activity by those in the aftercare program. Posthospital adjustment of patients who lived in families of procreation, who occupied central family positions, and who lived in intact families was better than that of other ex-patients. The main effect of the program was on those patients who were unmarried, who lived with families of origin, and who occupied peripheral family positions.

273. Maris, Ronald, and Connor, Huell E., Jr. Do crisis services work?: A follow-up of a psychiatric outpatient sample. *Journal of Health and Social Behavior*, 14(4): 311–322, 1973.

A study is reported which determined the relative efficacy of various treatment modalities in a crisis service unit within the emergency room of the Sinai Hospital, Baltimore. At the intake stage of the study, 200 consecutive psychiatric patients were interviewed. The interview schedule included self-satisfaction (Eaton Self-Esteem Bar) and depression (Arnold Lazarus Depression Inventory) scales, basic biodemographic questions, and questions concerning previous treatment, medication, psychiatric diagnosis, separations from parents, suicide history, quality of family interaction, and concepts of death. Followup interviews of 99 patients, similar in most respects to the intake group, were conducted 1 year later. Improvement was defined as a combination of more self-satisfaction and less depression. On this basis, 59 of the followup patients showed improvement, while 40 did not. The results of this study indi-

cate that improvment at followup was related to the amount of medication taken, but there was no statistically significant difference in improvement rates between those patients currently on medication and those not on medication, nor in improvement rates for either psychotics or nonpsychotics related to medication or according to the type of drugs administered. The results also indicated that improvement at followup was related to the duration and type of psychotherapy. The data reveal no significant overall differences by mode of therapy. Overall, however, patients who received individual therapy showed three times as many improved as unimproved cases. In all other therapy types, there were virtually no differences in improvement. Additionally, it is noted that improvement consisted not only in the absence of symptoms at followup, but also in conversion to more socially acceptable behavior. (34 references)

274. Markson, Elizabeth. The geriatric house of death: Hiding the dying elder in a mental hospital. *International Journal of Aging and Human Development*, 1(1): 37-49, 1970.

Reported is a study of a group of 174 elderly patients admitted to a New York State hospital during an 8-month period of 1967, to discover the processes of hospitalization. Family and professionals seemed to have sent away these people because they were "taking too long" to die. The sample included 105 women age 65 to 99, and 69 men age 65 to 104. Twenty-five percent of the sample died within 30 days after admission. Postadmission physical exams indicated that older people with a multiplicity of physical illnesses were being sent to the mental hospital. Less than half the group were able to walk without assistance at admission. Mobile patients were much less likely to die. The initial impetus to define these older patients as mentally ill began with their families for about three-quarters of the group. In no case did specific complaints significantly differentiate living from dying patients. These data suggest that the patients were known to be dying at the time of referral to the State hospital. The older patient seems to be selected for transfer to the State hospital first because he was considered hopeless by family and physicians; second because there was pressure for hospital beds; and third because he compounded the low status of old age with illness and often poverty. (27 references)

275. Marrone, Thomas R., and Anderson, Nancy. Innovative public school programming for emotionally disturbed children. *American Journal of Orthopsychiatry*, 40(4): 694-701, 1970.

Described is a cooperative effort between a county division of special education and school districts within the county to

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provide education and group therapy for emotionally disturbed children. The county hired the teachers and aides, provided equipment and supplies, and selected children for the classes. The local school districts provided psychiatric and psychological expertise and classrooms. Using the diagnostic nomenclature of the American Psychiatric Association, 13 percent of the 73 children in this study were psychotic, 21 percent neurotic, 20 percent had personality disorder, 40 percent had behavioral disorders, and 6 percent were scattered among nonpsychotic organic syndromes. For each class there was a teacher, an aide, and eight or nine children. The therapeutic methods used were group therapy, behavior modification for extreme control problems, and chemotherapy for one-fourth of the children. The educational approach was designed to provide individual instruction in reading, math, spelling, and writing. Group instructional methods were used for social studies, science, art, music, and physical education. Parents were contacted by social workers, and made biweekly written reports on the child's behavior at home. After 4 years of the program's existence, the reintegration rate into regular classes was 35 percent of the 73 children who made up the program.

276. Marsh, Velma, and Friedman, Robert. Changing public attitudes toward blindness. *Exceptional Children*, 38(5): 426-428, 1972.

277. Marx, Arnold J.; Test, Mary Ann; and Stein, Leonard I. Extrahospital management of severe mental illness. *Archives of General Psychiatry*, 29(10): 505-511, 1973.

An experiment is reported in which 61 patients of a State mental hospital with a prognosis of "not currently capable of sustained community living" were randomly assigned to one of three groups: an experimental Community Treatment Group (CTG), or one of two control groups. The CTG patients were moved into the community, regardless of symptomatology. "Treatment" consisted of participation in a full schedule of daily activities in the community. Activities of staff were motivating, supporting, and often being by patients' sides day and evening. In one of the control groups, patients received staff time and attention equal to CTG. These patients participated in an inhospital treatment program focused on "preparation" for community living. They were assigned to ward details, industrial therapy work assignments, and social-recreational activities. The second control group received usual treatment in the hospital. Patients in both the CTG (N = 21) and the first control group (N = 20) rendered their respective therapy programs for a 5-month period, with the programs structured to discharge the subjects from active treatment at this time. The three groups did not differ significantly on demographic varia-

bles, psychiatric history, or symptomatology at the beginning of the study period. At the end of the 5-month active treatment phase, an analysis of variance indicated that patients in the CTG had attained significantly more autonomous living situations and more autonomous job situations than either control group. The treatment approaches had no differential effects on symptomatology and self-esteem of the patients in the different groups.

278. Marx, John H., and Spray, S. Lee. Psychotherapeutic "birds of a feather": Social-class status and religio-cultural value homophily in the mental health field. *Journal of Health and Social Behavior*, 13(4): 413–428, 1972.

279. Mayer, John E., and Rosenblatt, Aaron. Clash in perspective between mental patients and staff. *American Journal of Orthopsychiatry* 44(3): 432–441, 1974.

A comparison of mental patients' opinions and hospital staff opinions is presented. Interviews were held with a sample of 220 patients and 119 staff members by social workers and patients, and self-administered questionnaires were given to 45 percent of the staff at different meetings. Patients had a more positive view of the hospital than any staff group. Patients and staff were also asked which factors were most important in helping patients get better, next most important and so forth, with values ranging from 5 for most important, to 1 for least important. Patients assigned roughly equal importance to eating, talking about problems, sleeping, medication, and keeping busy. Staff consistently rated talking and medication as more important than the other three, with the exception of attendants, who ranked eating before talking. Psychiatrists said medication was most important. Psychologists and social workers selected talking as most important. Rehabilitation workers ranked keeping busy the most important.

280. McDonald, Robert D.; Neulander, Arthur; Holod, Olga; and Holcomb, Nancy S. Description of a non-residential psychogeriatric day care facility. *The Gerontologist*, 11(4): 322–328, 1971.

The operation of a nonresidential psychogeriatric daycare center caring for 40–50 patients per month is briefly described with respect to staffing patterns, physical facilities, patient population, cost approximations and logistical arrangements. The report is based upon a 4-month period of observation of the Geriatric Day Care Center (GDCC) in Syracuse. The GDCC opened in August 1967, to provide therapeutic continuity for psychologically impaired elderly; to offer community education and case finding; and to develop new supportive services. The GDCC had a staff of one psychiatrist, two social workers, two registered nurses, four attendants, an occupational-recrea-

tional therapist, and a secretary. To be eligible for admission, individuals must have been residents of the area and their primary problem psychiatric. There were no age limits. During the period from August 1967 to August 1970, 139 patients with a mean age of 69.7 were served. A majority of the patients were white, widowed, Protestant, females living in private homes and apartments with family or friends. The most frequent primary diagnosis was psychosis associated with other cerebral condition. In the first phase of the program, new admittees were encouraged to take increased responsibilities for themselves. After an improvement in social relationships, personal appearance, and some capacity for initiative, support and encouragement were progressively withdrawn. In the third phase, patients had freedom to attend the GDCC or not as they wished. Reality orientation classes were divided into three levels according to functional categories. Seventy-five percent of the patients who had been attending less than a year had progressed to the second and third rehabilitative phases. Total cost from March 1969 to February 1970 was $103,852.70, with an average of 41.6 patients attending. Cost per patient averaged $10.41 per day. These costs are much less than conventional residential facilities. (19 references)

281. McGarry, Michael S., and West, Stephen G. Stigma among the stigmatized: Resident mobility, communication ability, and physical appearance as predictors of staff-resident interaction. *Journal of Abnormal Psychology*, 84(4): 399–405, 1975.

The results of two studies investigating the relation between three types of resident stigma and staff-resident interaction in a training center for the mentally retarded are reported. In the first study, 26 staff members were administered a questionnaire requesting demographic data, the amount of free time per hour that the staff member spent in positive and negative interaction with each resident, and a rating of each resident's mobility, communication ability, and appearance. Resident communication ability and physical appearance were significant predictors of staff-approval interactions, and resident mobility was the only significant predictor of staff-disapproval interactions. In the second study, interacting patterns of 17 staff with 46 residents were observed. Resident mobility was the only predictor of the resident-initiated neutral and disapproval interactions, whereas resident mobility, communication ability, and physical appearance were significant predictors of staff-initiated approval and disapproval interactions. (17) references)

282. McKinlay, John B. Some approaches and problems in the study

of the use of services—an overview. *Journal of Health and Human Behavior*, 13(2): 115-152, 1972.

A literature review of what has appeared in the last two decades concerning the use of health and welfare services in the United States and Europe is provided. Several analytically distinct approaches in the study of utilization behavior are identified, economic, sociodemographic, geographic, social psychological, sociocultural, and organizational. Research on utilization is examined. Methodological questions are raised concerning the work in this area to date, and new possibilities for utilization behavior research are suggested. (355 references)

283. McKinnon, Archie J. Parent and pupil perceptions of special classes for emotionally disturbed children. *Exceptional Children*, 37(4): 302-303, 1970.

284. McManus, John E. The proctor program for detention of delinquent girls. *Child Welfare*, 55(5): 345-352, 1976.

285. McNeil, Frances. A half-way house program for delinquents. *Crime and Delinquency*, 13(4): 538-544, 1967.

The operation and philosophy of a halfway house in Flint, Michigan, are presented. The halfway house is defined as a childcare facility in a community setting for delinquent boys committed to the State by county probate courts. Five childcare staff members worked 8-hour shifts; there are no live-in staff. A caseworker supervised the program and staff. Boys were referred by child welfare workers or by training school counselors. Criteria for admission included average intelligence, minimum age of 15, no consistent pattern of personal assaults or homosexual offenses, able to accept limits set by adults, able to accept responsibility for their own behavior, and reality oriented. The philosophy of the house involved the boys in the decisionmaking process necessary to get along in the community. As a result, rules were few but specific. Restriction on free time was the only punishment. Group discussion was used to explain decisions about a particular boy. To stay and work toward release meant the youth must, through his own will and desire for change, modify former behavior patterns. Each boy received 1-3 hours of individual attention each week by the caseworker and participated in one weekly group discussion of 1-3 hours. At the end of the first 6 months, six of the original eight were still in the program.

286. McWilliams, Spencer A., and Morris, Larry A. Community attitudes about mental health services. *Community Mental Health Journal*, 19(2): 236-242, 1974.

287. Meade, Anthony C. The labeling approach to delinquency: State of the theory as a function of method. *Social Forces* 53(1): 83-91, 1974.

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Hypotheses regarding selective bias on the part of official decisionmakers in the processing of juveniles and the independent effect of social control upon delinquency recidivism are tested. A random sample of 500 was selected from the 8,476 delinquent offenders recorded by a county juvenile court in a large southeastern metropolitan area for the years 1968 to 1970. Race, social class, sex, age, family structure, school status, offense, and case disposition were successfully identified for 438 cases. No bias against recidivists in offender disposition was demonstrated. A statistically significant direct relationship was observed between the severity of disposition and continued delinquency. This relationship suggested the emergence of secondary delinquency but seemed insufficient for testing the basic propositions of labeling theory.

288. Mendel, Werner M., and Rapport, Samuel. Determinants of the decision for psychiatric hospitalization. *Archives of General Psychiatry*, 20(3): 321–328, 1969.

A detailed analysis of 269 consecutive decisions for or against psychiatric hospitalization made by 33 professionals, including social workers, psychologists, resident psychiatrists, and staff psychiatrists is reported. The decision was influenced by both the profession of the decisionmaker and the clinical experience of the decisionmaker. Response to a questionnaire filled out by the 33 decisionmakers 1 month after the 8-day period under study and results of an interview with each decisionmaker provided data. Social workers tended to hospitalize significantly fewer applicants than did psychologists and psychiatrists. The more clinically experienced the decisionmaker, the less likely to hospitalize patients. The decision for hospitalization was not related to decisionmakers' estimate of severity of symptoms. If the patient had been hospitalized previously, his chance for being hospitalized at the time of this study was more than doubled. However, a history of previous hospitalization was not related to severity of symptoms. Availability of support resources to the patient significantly influenced the decision to hospitalize. All reported that severity of symptoms of the patient was a major factor, but none felt that his decision for or against hospitalization was influenced by the history of previous hospitalization. The results on the interview in comparison to the self-administered questionnaire, show that significantly fewer decisionmakers were willing to say that severity of symptoms was the major factor in the decision for or against hospitalization. Differences in results from questionnaire and interview were most marked among residents and least marked among staff psychiatrists and staff social workers.

289. Menolascino, Frank J. A system of services for the mentally retarded offender. *Crime and Delinquency*, 21(1): 57-64, 1975.

290. Meyer, Roger J.; Stafford, Richard L.; and Jacobsen, Milton D. Patterns of family followups: A study of children with mental retardation and associated developmental disorders. *Community Mental Health Journal*, 6(5): 393-400, 1970.

A sample of 100 children with a primary diagnosis of mental retardation and their families is used to study needs of and services given to the families in relation to child and family variables. Six months after an initial workup, each family was evaluated by means of a structured, precoded interview questionnaire, which contained 135 statements concerning age, sex, race, place of residence, family income, diagnosis, and source of referral. Clinical management was assessed by parents in terms of defining the problem, medication, and help with the developmental, social, emotional, and school problems. Ninety out of 100 cooperated in the followup study. There was a significant positive correlation between help requested and help actually received. Nonwhite families desired more help for home problems, requested more medication, and needed more assistance in defining the problem than did white families. Families in which the mother did not work were more likely to have emotional problems, to want medical help, and to want more extensive explanation of the problem. There was no significant difference between children in families in which the mother worked, as compared to mothers that did not work, regarding type or severity of clinical problem. The severely disabled did not require more medical aid than did the less severe, nor was more home help needed. The local physician was less helpful with the child with the greater retardation severity.

291. Michaux, Mary H.; Praim, Robert J.; Foster, Shirley A.; and Chelst, Marvin R. Relatives' perceptions of rural and urban day center patients. *Psychiatry*, 36(2): 203-212, 1973.

Investigation is made of the extent to which results of studies of urban psychiatric patient-family interaction can be generalized to rural residents by comparing and evaluating patient samples from a rural and an urban daycare center. Dissatisfaction with patient performance seemed consistently greater in urban than in rural families. The sample consisted of 49 consecutive new admissions to a rural day center; 40 randomly selected patients admitted to an urban day center; and a close relative of each patient. The Katz Adjustment Scales (KAS) and the Michaux Stress Index (MSI) were used to evaluate subject reactions to environmental pressures as reported by the patient himself and by his relative. The two

samples differed significantly on only one clinical or demographic characteristic—social class. The typical day patient was middle aged, middle class, white, and female. Family perception of and satisfaction with the patient member were largely independent of socioeconomic factors. Expectations of the patient were more congruent with actual functioning in the rural than in the urban group. Relatives' perceptions of patient's role performance more nearly resembled those of the patient in rural than in urban families. Rural patients and their relatives perceived about the same level of external stress in the life situation of the patient, whereas urban patients appeared to have experienced environmental pressures of which their relatives were unaware. Urban patients, to a greater extent than rural patients, were seen by their families as difficult and disinterested.

292. Miller, Clark J.; Mayer, Deborah; and Whitworth, Wallace E. A study of mentally retarded juvenile offenders in Corpus Christi, Texas. *Federal Probation*, 37(2): 54-61, 1973.

293. Miller, Lovick C. Southfields: Evaluation of a short-term inpatient treatment center for delinquents. *Crime and Delinquency*, 16(3): 305-316, 1970.

Reported is an evaluation of Southfields, a Kentucky replication of New Jersey's Highfields program for the treatment of delinquents, based on four annual evaluations. The program at Southfields seeks to establish a culture which contains the values of the dominant culture. Recidivism rates for 191 boys admitted to Southfields during the 4-year period were compared with rates of 157 boys placed on probation, 162 boys assigned to a correctional institution, and rates at Highfields. Court officials assigned a boy to Southfields, probation, or parole according to their judgment of the most suitable placement for him. These assignments were apparently based on the degree of delinquency. Boys were rated as Failure (recidivated), Success Group A (no recommitments and no serious offenses within one year after release), or Success Group B (no recommitments, but charged with or convicted of serious offenses in the year after release.) Success Group A included 77 percent of those on probation, 70 percent of Southfields' graduates, and 53 percent of those assigned to the correctional institution. Eleven percent of Southfields' graduates and 15 percent of the probationers were classed as Failures. These two groups differed significantly from the correctional institution group. Southfields' rates were found to be superior to Highfields'. The study indicated that the Southfields program should be the second stage in a three-step remedial program,

probation being the first and the State correctional institution the third step. (3 references)

294. Miller, Warren B. A psychiatric emergency service and some treatment concepts. *American Journal of Psychiatry*, 124(7): 924-933, 1968.

295. Millman, Howard L. and Schaefer, Charles E. Behavioral change: Program evaluation and staff feedback. *Child Welfare*, 54(10): 692-702, 1975.

296. Mishara, Brian L.; Budd, Richard D.; and Dixon, Theressa. Transferring elderly patients from mental hospital to nursing home. *Hospital and Community Psychiatry*, 24(12): 837-838, 1973.

297. Mishne, Judith. Group therapy in an elementary school. *Social Casework*, 52(1): 18-25, 1971.

298. Moos, Rudolf. Assessment of the psychosocial environments of community-oriented psychiatric treatment programs. *Journal of Abnormal Psychology*, 79(1): 9-18, 1972.

The development of a scale to discriminate among the perceptions of members and the perceptions of staff of different types of treatment programs is described. The Community-Oriented Programs Environment Scale (COPES) assesses the psychosocial environments of transitional community-oriented psychiatric treatment programs in a manner similar to that of the Ward Atmosphere Scale (WAS). A 130-item form B of COPES adopted from the WAS was administered to 373 members and 203 staff in 21 different community-oriented treatment programs. Half the programs tested served as transitional residences for ex-mental patients, and the other half served persons in the community as an alternative to hospitalization. Items were initially sorted by agreement between three independent judges into 12 subscales which paralleled the WAS subscale used to assess the social environment of psychiatric wards. A 102-item Form C of COPES was derived. The 10 subscales of Form C included program involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, anger and oppression, order and organization, program clarity, and staff control. Means and standard deviations of subscale scores were calculated for each program for members and staff for each of the subscales. One-way analyses of variance indicated that the 10 subscales differentiated among the 21 programs for both members and staff responses.

299. Omitted.

300. Moos, Rudolf H. *The Human Context: Environmental Determinants of Behavior*. New York: Wiley-Interscience, 1976.

A review is presented of the main schools of theory and

research concerning the impact of the environment on human behavior. Concepts and theories are drawn from a number of fields including geography, architecture, community psychology, social psychology, organizational behavior, and others. The book is organized in four parts: history, physical environment, social environment, and utopian ideas. One chapter deals with "social climate" or the "personality" of the environment. Social environments are conceptualized as having three underlying sets of dimensions including relationship dimensions, personal development dimensions, and system maintenance or change dimensions. Variable properties of environment, it is theorized, may be identified under each of these three headings for such diverse types of environment as families, university living groups, classrooms, or hospital and community programs. For hospital and community programs there are three dimensions suggested for each of the three types of dimensions. The relationship dimension includes involvement, support, and spontaneity. The personal development dimension includes autonomy, practical orientation, and personal problem orientation. The system maintenance dimension includes order, clarity, and control. Further, it is suggested that main outcome criteria from social environments are of three major types: satisfaction criteria, objective criteria such as academic achievement or work productivity, and health-related criteria. With respect to psychiatric treatment settings, research reported elsewhere is summarized as showing that relationship dimensions are of prime importance. Programs with high release rates are strong in system maintenance and practical orientation with many activities and preparation for release. Programs which keep patients in the community longest emphasized expression of feelings, autonomy, practical orientation, and order.

301. Morris, Robert. Completing the health system through personal care benefits. *International Journal of Aging and Human Development*, 4(2): 157-165, 1973.

An alternative to the present health system is discussed along with the role of social and medical factors in health. The major approach to the combination of social and medical needs has been comprehensive and physician-directed. The approach proposed includes parallel and independent structures, one social and one medical. The present comprehensive structure favors medical and income provision to the neglect of other social needs. Yet, the health needs of the aged are primarily economic and social in nature and include personal care, home maintenance assistance, transportation, income supplementation, opportunity for socialization, and hous-

ing. There is an imbalance in favor of medical over social services, as evidenced by the lopsided expenditures under Medicare and Medicaid. A personal care benefit comparable to the present medical benefit should be established. Entitlement to the personal care benefit would be determined by a measure of capacity for self-care and maintenance. A personal care benefit would finance social services, optimize choice for the patient, and minimize layers of organization.

302. Mosher, Loren R.; Menn, Alma; and Matthews, Susan M. Soteria: Evaluation of a home-based treatment for schizophrenia. *American Journal of Orthopsychiatry*, 45(3): 455-467, 1975.

Preliminary results from an experimental community residence-based program for young first-admission schizophrenics are interpreted as positive. Establishment of peer-group relations were encouraged by small homelike facility staffed by young nonprofessionals. Successful peer relations were interpreted as responsible for higher psychiatric and social adjustment. "Soteria" was a six-bed transitional residential facility operated around the clock by six paid staff. Staff helped patients deal with problems of living and identity through discussion and personal influence. The treatment regimen included normal living patterns. Experimental design was random assignment of young first-admission schizophrenics to Soteria or to an inpatient ward having a good program. Demographic and psychiatric measures showed no important differences between the first 20 experimental patients and 24 control patients. Scales to measure the treatment environments indicated Soteria to be more supportive personally and less authoritarian than inpatient treatment. Medical records showed less use of chlorpromazine hydrochloride (Thorazine). Referral to other community services was not part of the program. Outcome measures indicated significantly more normal role performance, such as working for pay, attending school, leaving home, and having a girl or boy friend. Soteria residents also showed less psychopathology as judged by independent evaluators, and no more readmissions than the experimental group. Cost of both experimental and control treatment was about $4,400 per person. The authors believe that better social adjustment and lesser use of drugs for therapy by Soteria residents was due to longer residence which encouraged modeling after emancipated young staff, learning of new peer relation patterns, and which also gave patients' families time to regroup.

303. Mosher, Loren R.; Reifman, Ann; and Menn, Alma. Characteristics of nonprofessionals serving as primary therapists for

acute schizophrenics. *Hospital and Community Psychiatry*, 24(6): 391-396, 1973.

Ten nonprofessional staff of Soteria House, 1971-1972, are characterized as to their selection, their personalities, therapy styles, and performance on standard exams. The Soteria House program treated schizophrenia as an altered state of consciousness and an opportunity for personal growth. The treatment was accordingly a humanistic effort by a nonprofessional to understand and help the patient deal with his experiences. Soteria House had 20 applicants for four positions involving daily living and emotional interaction with six young first-episode schizophrenic patients. Selection and training emphasized empathy, ability to express and respond to feelings, and ability to sustain anxiety and negative feelings in an instructive situation. Of the first 10 workers there were five men and five women, mean age 27.6 years, mostly single. Experience in mental health averaged 3 years. Social class background was middle and working, and education averaged 15 years. The most striking common feature was that nine of their families of origin were problem families with an alcoholic or disturbed parent. The staff member had ordinarily acted as a somewhat neutral caretaker of the disturbed parent. Usually a sibling had exhibited disturbance or breakdown, but not the staff member. Standardized tests supported the observation that the staff were independent, creative, and intelligent.

304. Moss, Bertram B., and Lavery, Mary Ellen. Review of a new community health care evaluation and service center. *The Gerontologist*, 14(3): 207-209, 1974.

A community health care evaluation and medical service for the elderly in a pilot area of Chicago revealed that old people were almost universally receiving some degree of medical attention but were not making good use of medical services due to psychosocial and practical barriers. An outreach service was begun in June 1972, in a target area with 5,100 elderly, by the Council for Jewish Elderly. The medical department staff included a half-time coordinator, a fourth-time medical clinician, a full-time registered nurse assistant coordinator, and a full-time registered nurse for home-health care. In the first year, 448 clients were seen, all receiving medical attention from either private or clinic physicians. Major problems of the clients included improper self-medication, improper utilization of medical services, inability to purchase high-cost drugs, and malnutrition. The medical department was not created to supply medical care, but to follow the concept of minimum

intervention and to be the catalyst, supporting quality medical care and service. Clients' physicians were asked how they could be helped. Patients were encouraged to use the program's transportation to and from their physician's office and to accept help in carrying out doctor's orders. Services offered include medical social services, such as health education, health care, and mental health counseling. Hospital services were obtained through contractual arrangements. Education of indigenous nonprofessionals, rehabilitation, and the prevention of disability on an outpatient basis were also goals of the health-care team.

305. Munns, John G.; Geis, Gilbert; and Bullington, Bruce. Ex-addict streetworkers in a Mexican-American community. *Crime and Delinquency*, 16(4): 409-416, 1970.

Results from the first year of the Boyle Heights Narcotics Prevention Projects are reported. This project was an attempt to decrease addiction in a Mexican-American area by employing 30 former addicts as fieldworkers. There was a higher rate of return to addiction among the fieldworkers than prediction tables anticipated. The project developed a controversial employment program that manipulated employers in the service of clients and a successful detoxification center. The project began in 1967 and offered such services as withdrawal facilities, family counseling, employment services, intervention with correctional agencies, and group therapy to anyone requesting them. To qualify as a fieldworker, applicants must have been drug-abstinent for at least 6 months and have had some familiarity with the target area. During the first year, 36 people were employed, only 8 of whom were still working at the end of the second year. Of the other 28, 15 were known to have returned to drug use and 2 were likely suspects. "Active" clients were those who maintained a relationship with the project for more than 30 days and were continuing to maintain contact. At the end of the first year, there were 231 active clients, with an average between 30-39. Almost 90 percent were Mexican-American males, and two-thirds were under some kind of correctional control. The active clients indicated their major problems were employment (53 percent), drug use (25 percent), lack of residence, clothing, or social life (9 percent), and family problems (5 percent). Getting jobs was seen as the project's main task and was delegated to the Job Development section. This section was willing to jeopardize its relations with an employer in order to place an addict. The staff developed an elaborate set of deceptions and estimated that 75 percent of

their placements were under false pretenses. They placed 238 persons in the first year, but were unsuccessful with 199 applicants. For detoxification, a "kick-pad" with 24-hour attendance by fieldworkers was established. From January to July 1969, 182 people entered the kick-pad, of whom 104 remained until they completely withdrew from physical dependence on opiates. The project developed a role as mediator between its clients and correctional agencies. The courts placed some clients in the custody of the project. About 2,000 used the service in the first year. (15 references)

306. Muth, John W., and Singell, Larry D. Costs and benefits of training educable students: The Kansas work-study project reconsidered. *Exceptional Children*, 41(5): 334-335, 1975.

Cost data from an earlier followup study (Chaffin 1971) of 30 educable mentally retarded individuals who participated in the Kansas Work-Study Project are reexamined to determine the economic efficacy of the project. The total project costs over 3 years were $157,077 in excess of the costs of educating these students in regular classrooms. Benefits of the project were measured as the wage differential between the experimental group and those in the comparison group without special training. Using this method, the annual total income differential, adjusted for the difference of the unemployment rates between the two groups, amounted to $60,724 in the first year after the program and declined to an estimated $32,718 in the sixth and successive years. Even after discounting the benefits, these results suggest that the project was very successful, even if the income differentials that were discovered between the experimental and comparison group continue for only a 3-to-5-year period. (1 reference)

307. Nathanson, Barry F., and Reingold, Jacob. A workshop for mentally impaired aged. *The Gerontologist*, 9(4): 293-295, 1969.

308. Nathanson, Constance A. Peer surveillance and patient orientation in a pediatric out-patients clinic. *Human Organization*, 30(3): 255-265, 1971.

309. Neff, Walter S., and Koltuv, Myron. Toleration for psychiatric rehabilitation as a function of coping style. *Journal of Consulting Psychology*, 31(4): 364-370, 1967.

310. Nejelski, Paul. Diversion: The promise and the danger. *Crime and Delinquency*, 22(4): 393-410, 1976.

Four diversion projects are described, and implications for civil rights of juveniles are discussed. In the New Jersey Juvenile Conference Committees, committees of citizens were con-

vened to hear minor complaints against children and to work out solutions. An estimated 10 percent of the juvenile cases in the State were diverted to committees. Dispositions included dismissal and requiring the youth to make repairs or apologize. Committees often placed juveniles "on probation," though they had no authority to do so. The Sacramento County 601 Diversion Project provided immediate, intensive family counseling by probation officers. Only the first session was mandatory. Preliminary results indicate that project cases were referred to court much less frequently than control group cases, recidivism for the project was lower than for the controls, and overnight detention was reduced for the experimental group. The Van Dyke Youth Service Bureau operated a 12-bed cottage for "predelinquent" young women where counselors were available throughout the recommended 5-day stay. The girls were not confined, guarded, or observed, and were free to leave and refuse counseling. Only 5 of the 250 girls ran away. There were indications of a lower recidivism rate. The Bronx Neighborhood Youth Diversion Program operated in the black and Puerto Rican sections of the Bronx with youths aged 12-15. Youths were assigned to an advocate who was usually younger than 30 and lived in the youth's neighborhood. The advocates counseled the youths and directed them to other resources. These referrals were reviewed every 2 or 3 weeks. In all of these programs, concern about establishing guilt or innocence appeared secondary to the desire to rehabilitate youths. Better criteria were needed to decide which cases would go before the judge and which would be diverted. To insure due process, there should be judicial review of diversion decisions. There could be a danger that diversion programs increase coercive intervention in the lives of children and their families without proper concern for their rights. (40 references)

311. Neuhaus, Maury. Parental attitudes and the emotional adjustment of deaf children. *Exceptional Children* 35(9): 721-727, 1969.

312. Nielsen, Margaret; Blenkner, Margaret; Bloom, Martin; Downs, Thomas; and Beggs, Helen. Older persons after hospitalization: A controlled study of home aide service. *American Journal of Public Health*, 62(8): 1094-1101, 1972.

Described are the effects of an organized program of home aide services on the survival, contentment, and institutionalization of patients discharged from a geriatric rehabilitation hospital. Patients were selected for the program on the basis of being 60 or over, not requiring intensive skilled nursing or custodial care, having a noninstitutional place of abode, and

not already be receiving home aide, homemaker, or visiting housekeeper service in the community. These criteria yielded a group of 100 advantaged patients whose median age was 74, one-third of whom were males, 92 percent of whom were white and whose most common reason for being in a rehabilitation program had been hip fracture (35), stroke (24), arthritis (22), and a miscellaneous category (19) of neurological, locomotor, and vascular disorders. These patients were assigned to experimental and control groups through random sampling procedures which produced an exact match on sex, a good match on diagnostic group, less than a year's difference on median age, and were fairly equal in regard to the presence of a potential caregiver in the household. The study itself was conducted not so much as a study of home-aide services as a study of the effect of institutionalization on survival. The home-aide service was seen by the designers of the research as a manipulable intervening variable which might produce a real test of the hypothesized negative relationship between institutionalization and the survival variables. Unexpected willingness and capacity to care for their old among families of controls precluded the attainment of this objective. Periodic, structured (closed-form) interviewing and observation by the research staff were used as the primary source of data regarding outcomes. These outcomes revealed no significant difference in the survival rates of the experimental and control groups, a favorable difference in change in contentment for the experimental group as measured by a contentment index ($p < .10$) and a contentment observer rating ($p < .02$), and fewer days in (8 days versus 53 days) and fewer patients admitted to long-stay institutions in the experimental group. Home-aide service had the most significantly favorable impact on contentment among arthritics and fracture patients and on institutionalization among those who had someone who could be a potential caregiver living in the household. The study demonstrated that generous home-aide service can cut down hospital and nursing home admissions. (12 references)

313. Nooe, Roger M. Toward independent living for the mentally retarded. *Social Work*, 20(4): 286-290, 1975.

A transitional living facility program for mentally retarded adults is described. The program staff consisted of a doctor, two resident counselors, two alternate counselors, research consultant, secretary, and several student volunteers. Residents were at least 18 years of age, had demonstrated a moderate level of social functioning, were free from severe emotional or physical disability, and wished to enter the program.

Four men and four women made up the first group of residents. Seven had been institutionalized for periods of from 5 to 30 years. IQs ranged from 51 to 62. The second group of residents was composed of four men and three women, hospitalized from 5 to 27 years, and with IQs from 46 to 68. An unstructured orientation period of 4 to 6 weeks began each new resident's stay in the program. Residents participated in planning programs. Activities included job finding, maintenance of the home, and preparing one evening meal per week. Termination from the program was initiated by either staff or a resident and was a month-long process of preparation. Ratings were made of residents' basic skills in communication, basic reading, and arithmetic, money management, personal needs, purchase and preparation of food, public transportation, recreational activities, problem solving, interpersonal behavior, and organization and planning. Pre- and post-ratings of eight residents showed that six of the eight progressed in the development of each of the skills. Within 14 months, seven of the eight original residents moved into the community. Four live alone, two share an apartment, and three hold full-time jobs.

314. O'Brien, Charles P.; Hamm, Kyle B.; Ray, Ben A.; Pierce, James F.; Luborsky, Lester; and Mintz, Jim. Group vs. individual psychotherapy with schizophrenics. *Archives of General Psychiatry*, 27(10): 470-474, 1972.

315. O'Connor, Alice L. A creative living center for the mentally ill. *Social Casework*, 51(9): 544-550, 1970.

Described is an experimental project, Creative Living Center, which offered a program of social activities and problem-solving groups for mentally ill persons in the community and attempted to prevent rehospitalization. In spite of early funding and staffing problems, the weekly program provided arts and crafts, singing, dancing parties, problem-solving groups, role playing, group discussions, story completion, creative writing, and outdoor sport activities for its participants. In all these activities, effort was directed toward eliciting from the participant the personal significance of his finished product. The program was not a day-treatment program since no medication groups, medical or paramedical personnel, nor sophisticated group therapy or confrontation groups were provided. In spite of its many problems, the program, based on staff's observations, appears to have been effective in helping prevent rehospitalization of this group of patients. The participants grew more interested in the center and its activities and became more adapted to their community.

316. O'Connor, Gerald G. The impact of initial detention upon male delinquents. *Social Problems*, 18(2): 194-199, 1970.

A field study is reported on the question whether the initial detention experience pushes the delinquent toward assimilation or alienation from society. Findings support the idea that a combination of an initial negative attitude by the boy with custodial orientation by the facility produces a move toward alienation. A total of 34 boys from custody institutions and 26 from socialization facilities were tested just after detention, and again about 2 weeks later, at the time of their hearing. Gough's Socialization Scale for role taking and the Delinquency Check List for acceptance of delinquent behavior were both administered, and results were analyzed separately. Neither the initial delinquent orientation nor the orientation of the facility predicted moves toward being more open or closed to assimilation by society. But when the two factors were combined, producing a set of four categories, then the expected ranking was achieved among the four categories. Although the Chi-square value was still over .1, the observation of the expected rank among several categories permitted the conclusion that interaction between boys' and facilities' orientations did produce an effect. It is suggested that more attention be paid to this first period of detention, since boys' attitudes may be especially subject to change at this time. (20 references)

317. Ohlin, Lloyd E.; Coates, Robert B.; and Miller, Alden D. Evaluating the reform of youth correction in Massachusetts. *Journal of Research in Crime and Delinquency*, 12(1): 3-16, 1975.

Preliminary findings are presented of a 7-year project by the Center for Criminal Justice at the Harvard Law School to study the reforms undertaken by the Massachusetts Department of Youth Services (DYS) to close training schools and substitute a diversified network of community-based correctional services for youth. The network consists of a large purchase-of-service system with regional offices making case decisions. Treatment ranged from group homes to foster care and nonresidential programs. A series of observations and interviews with a cohort of DYS clients entering the Department in 1973 and 1975 was undertaken. In July 1974, on a typical day, there were 132 youths in secure care, 399 in group care, 171 in foster care, 724 in nonresidential care, and 941 on parole for a total of 2,306, as compared to a day in June 1968, under the old program, with a total of 2443. The new programs have not resulted in bringing more youth into the correctional process. The percentage of youth over 15 years of age has increased from 33 to 68, suggesting that the reforms have produced different

referral and disposition patterns. Preliminary recidivism data show a drop from 49 percent to 24 percent for boys and no change for girls. A shift from a custodial to a communal atmosphere was noted. Evidence of negative subcultures has decreased. (10 references)

318. Olmsted, Donald W., and Durham, Katherine. Stability of mental health attitudes: A semantic differential study. *Journal of Health and Social Behavior*, 17(1): 35-44, 1976.

The question of whether popular attitudes toward mental health are changing is examined. Two comparable sets of college students responded in 1962 (215) and in 1971 (319) to a semantic differential scale on mental illness. A comparison of responses, utilizing correlation of concept and scale means, indicated (1) the perceptions of the public and of college students with respect to the mental health-mental illness domain are similar and parallel; (2) both groups are primarily concerned about the disruptive behavior of the mentally ill, rather than being concerned with psychodynamics; (3) both groups accept the authority of the experts regarding psychiatric labels; (4) both groups evaluate negatively those classified as mental patients and "Ex-Mental Patient"; (5) both groups are reluctant, or unable, to give up the notion of individual responsibility for actions; and (6) attitudes are firmly anchored in a cultural belief system that is not very susceptible to modification by external forces. (25 references)

319. O'Rourke, Thomas R., and Salem, Richard G. A comparative analysis of pretrial release procedures. *Crime and Delinquency*, 14(4): 367-373, 1968.

320. Osborne, Oliver H. The Yoruba village as a therapeutic community. *Journal of Health and Social Behavior*, 10(3): 187-200, 1969.

Described is a field study of several Nigerian community-based psychiatric treatment programs carried out to clarify the concept of "therapeutic community." The study of therapeutic communities in other cultural settings might suggest useful generalizations. The programs in Nigeria encouraged village household heads in areas near mental facilities to accept mentally ill patients. One member of each patient's family stayed in the home as a lodger, with most of the rights inherent in this status. The program permitted traditionally oriented patients to remain in a familiar cultural context and thereby reduced the possibility of culture shock, anxiety, and regression that often accompany admission to a psychiatric hospital. It is noted that such therapeutic programs must be sensitive to the political structure of the local community so that the

programs do not pose social or economic threats to the community. Such village therapeutic programs have not yet proved their superiority over hospital treatment. (25 references)

321. Otto, Jean A., and Moos, Rudolf H. Evaluating descriptions of psychiatric treatment programs. *American Journal of Orthopsychiatry*, 43(3): 401-410, 1973.

322. Otto, Jean, and Moos, Rudolf. Patient expectations and attendance in community treatment program. *Community Mental Health Journal*, 10(1): 9-15, 1974.

The Community Oriented Programs Environmental Scale (COPES) was used to assess the effect of the expectations of newly admitted members to four community based psychiatric programs. COPES forms were completed by the patients before, or within the first 2 days, of admission. The four programs studied included a patient-run unit in a Veterans Administration hospital, two daycare centers, and a day hospital. An independent assessment of the patients' use of the programs was made by a staff member. Patients were rated as "Good," that is, as having attended regularly and participated well in the program; or as "Poor," that is, as having been frequently absent and having made little use of the program. Initial expectations as measured by COPES were examined for 47 patients rated as Good and 26 patients rated as Poor. The expectations of patients who later did poorly in the program were higher on seven of the ten subscales than were the expectations of those who later did well. Both groups had similar expectations of how free they would be to express angry feelings (anger and aggression) and how orderly the program would be (order and organization). This study indicated that patients having unrealistically positive expectations have a greater likelihood of absenteeism, dropout, and poor participation in a program where the social milieu is neutral or somewhat negative. However, patients who experience the positive milieu they are expecting may be more likely to show good program adjustment than patients who do not.

323. Ozarin, Lucy D., and Witkin, Michael J. Halfway houses for the mentally ill and alcoholics: A 1973 survey. *Hospital and Community Psychiatry*, 26(2): 101-103, 1975.

Major findings from an NIMH-sponsored 1973 survey of halfway houses for alcoholics and mentally ill are summarized. Previous surveys found only 128 halfway houses in 1969, and 533 in 1971. The 1973 survey located and obtained information from 209 psychiatric halfway houses and 597 alcoholism halfway houses. The psychiatric halfway houses had some 6000 residents, mostly young adults, who stayed on the average

6 months to a year. At discharge about 40 percent moved to independent living, 22 percent to live with family and friends, and one-quarter to hospital or sheltered-living facility. Two-thirds of the patients had their primary support from public funds. Some 10,000 residents in halfway houses for alcoholics were mostly male, and age distribution was slightly older than the psychiatric residents. Length of stay in alcoholism facilities was less but at discharge residents seemed to be distributed to similar living situations as the psychiatric group. Further growth in halfway houses is predicted.

324. Padilla, Elena; Elinson, Jack; and Perkins, Marvin E. The public image of mental health professionals and acceptance of community mental health services. *American Journal of Public Health*, 56(9): 1524-1529, 1966.

Described are the findings of a survey on the public image of mental health services and personnel in New York City. This 1963 survey was based on a multistage probability area sample (N = 2,115) designed to represent the 5 million civilian non-institutionalized adults, age 20 and older, living in the city. Questions addressed include the awareness and experience of New Yorkers with mental illness, their opinions concerning mental illness, and their image of the mentally ill, their image of mental health professionals, their images and knowledge of mental health facilities and services, and their approval of and recognition of the need for community-based mental health services. In general, the results indicated a generalized acceptance of the need for various community mental health services particularly for those that provide immediate help. Although there was optimism about the treatment of mental illness, attitudes of rejection were not completely dispelled. Mental health professionals were not too well known to the public, and there was little public knowledge about specific services and available facilities. The greatest public preference was for those services which appeared to provide immediate help. There was less preference for services which bring mental patients back into the community and least for those which would place mental patients in a foster home. These preferences appeared to be consistent with the prevailing public images of the mentally ill and of the mental health profession. (0 references)

325. Palmer, Ted B. California's treatment program for delinquent adolescents. *Journal of Research in Crime and Delinquency*, 8(1): 74-92, 1971.

The effectiveness of California's Community Treatment Project (CTP), which has handled seriously delinquent youths

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committed to the State correctional system from four California communities since 1961, is evaluated in terms of six outcome measures including average number of suspensions per unit of time, recidivism within a 24-month followup, rate of favorable discharge from the California Youth Authority (CYA), rate of unfavorable discharge from CYA, psychological test-score changes, and rate of postdischarge arrests in a 24-month followup. Youths eligible for CTP averaged five known arrests, were 15.5 years of age, and an IQ of 89, and 80 percent were from lower socioeconomic backgrounds. All eligible cases in the juvenile court system were assigned by a stratified random procedure to either the CTP program (experimentals) or the traditional program (controls). Youths assigned to CTP were paroled back to their home community where successful completion usually took 2½-3 years. From 1961-1969, 686 experimentals and 328 controls were studied. Experimental and control groups were equated on age, IQ, socioeconomic status, race, and type of community offense. Based on an interview, each experimental youth was classified according to the Interpersonal Maturity Level (I-level) scale which referred to dominant ways individuals interpret their environment. Individual treatment strategies were then developed reflecting each youth's I-level, pattern of response to others, self-image, and life situation. Parole agents were assigned to work only with small caseloads (about 12) of those subtypes of youth with whom they appeared to be "matched." CTP parole agents working with specific youth subtypes had a number of professional and personal characteristics which statistically distinguished them from CTP parole agents working with other subtypes. Program elements potentially available as needed to all CTP youths were group homes or out-of-home placements; individual, group, or family therapy; flexible agent-youth contacts; surveillance; an accredited school program in CTP's community center; recreational and coeducational activities; short-term treatment; and detention. Experimental youths were ahead of controls in psychological testing and recidivism, rate of unfavorable discharge from CYA, and rate of parole suspensions. No difference was found between controls and experimentals in rate of favorable discharge from CYA or rate of postdischarge arrests. Thirty-nine percent of the boys appeared to do better within the experimental program; 10 percent did better in the control program; 27 percent did equally well in both programs; and 24 percent did equally poorly in both programs. Average yearly costs were $2300 in CTP, $5800 within CYA institutions, and $400 on regular

parole. It is suggested that CTP concentrate on dealing more effectively with the 24 percent who do poorly in both programs. (33 references)

326. Pappenfort, Donnell M., and Kilpatrick, Dee M. Opportunities for physically handicapped children: A study of attitudes and practices in settlements and community centers. *Social Service Review*, 41(2): 179-188, 1967.
327. Payne, Reed, and Murray, Charles. Principals' attitudes toward integration of the handicapped. *Exceptional Children* 41(2): 123-125, Oct. 1974.
328. Peretti, Peter O. Precipitating factors of readmission of psychiatric patients. *Community Mental Health Journal*, 10(1): 89-92, 1974.
329. Perrow, Charles. Reality adjustment: A young institution settles for humane care. *Social Problems*, 14(1): 69-70, 1966.

    A case study of development of a "humane care" orientation in one juvenile correctional institution is presented as a way of arguing that, in the absence of reliable treatment technologies, a humane-care approach is a desirable alternative to custodialism. The "treatment" orientation requires retraining of staff, a permissive approach to behavior control, and individual handling of inmates. The "humane care" model retains the goal of therapeutic intervention, but if treatment programs cannot be carried out, the staff still seeks to maintain a benign and friendly environment. Change is encouraged but is likely to come from life experience or other influences, not from a specific treatment regimen. A new juvenile correctional institution was observed twice in its first year of existence, then again in its 4th year of existence. The staff was treatment oriented at the first observation, but a riot and other occurrences caused the staff to move toward restrictive and punitive norms. The third study found a 3- to 9-month decrease in average length of stay. Fewer doors were locked, and staff-inmate relations were positive. Riots and other incidents had been easily and competently handled. There was no pressure from the community. Questionnaire results strongly confirmed the pattern of initial high-treatment orientation, a severe drop in that orientation during the first year, and a return of responses to somewhat below the mean for "treatment." In short, the humane-care model avoided some aggravating problems of the treatment model and permitted boys to work on changing their own behavior.

330. Peterson, Evan T. The impact of adolescent illness on parental relationships. *Journal of Health and Social Behavior*, 13(4): 429-437, 1972.

The relationship between health of adolescents and their families as self-reported by questionnaires is analyzed, with largely negative results. A sample of 3,311 male and 3,414 female adolescents from high schools across the United States completed structured questionnaires. Data were sought on sex, social class, parental approval or disapproval of the adolescents' activities, the degree of parental interest in a variety of adolescent activities, and the type of health that the adolescent had (perfect, perfect past, fair past, or chronically ill). Chi-square analysis of the relationship between health and selected familial variables, and of the relationship between health and selected extrafamilial and social-psychological variables, controlling in both cases for sex role and social class, indicated in general that the existence of a sociological syndrome descriptive of ill adolescents was not supported. Chronic illness only affected family interaction when adolescents became overtly ill. Illness affected self-perception and frequency of feigned illness. Chronically ill adolescents were not found to be socially inactive.

331. Petrov, Ignat H., and Vlahlyska, Lilia A. Cultural therapy in the old peoples' home. *The Gerontologist*, 12(4): 429-434, 1972.

333. Piedmont, Eugene B. Referrals and Reciprocity: Psychiatrists, general practitioners, and clergymen. *Journal of Health and Social Behavior*, 9(1): 29-41, 1968.

334. Pimm, June B., and McClure, Gordon. Working with emotionally disturbed children in the public school setting. *Exceptional Children*, 33(9): 653-655, 1967.

335. Pinardi, Norman J. The chronic drunkenness offender: What one city is doing about the revolving door. *Crime and Delinquency*, 12(4): 339-343, 1966.

336. Pincus, Allen, and Wood, Vivian. Methodological issues in measuring the environment in institutions for the aged and its impact on residents. *Internatioinal Journal of Aging and Human Development*, 1(2): 117-126, 1970.

Based on two exploratory studies involving 11 nursing homes, some methodological issues in measuring institutional environments and their impact on residents are discussed. Four issues for future research were extracted from the exploration studies: (1) differences in the perception of the institutional environment among staff and between staff and residents; (2) the relationship between the residents' behavior and their subjective opinions of the environment; (3) the relationship between the institution's ranking on the environmental dimensions and the behavior and subjective feelings of the residents; and (4) the relationship between residents' behavior and their subjective opinions of the environment and their

overall satisfaction with the environment. Four dimensions of institutional environments used in studying the geriatric institutions were: the public-private dimension or privacy; the structured-unstructured dimension or freedom; the resources dimension; and the isolated-integrated dimension or integration. A measuring instrument called Home for the Aged Description Questionnaire (HDA) was used to measure these four dimensions. As a result of a factor analysis of the 36 questions in HDA, a fifth dimension was added: personalization or social distance between staff and residents. The HDA was administered to a 50 percent sample (N=263) of the staff at three homes. At one home a sample of 89 residents completed the same HDA, out of a total population of 239. The residents in the sample were similar in age, sex, and length of stay to the whole resident population. Staff, more than residents, saw the environment as providing freedom and resources. Residents, less than staff, saw the institution as isolated from the community. Subjective feelings about the environmental dimensions were more predictive of overall satisfaction with the institution than was the residents' overt behavior. Availability of privacy seemed to play a central role in the level of resident satisfaction with regard to all four environmental dimensions. (8 references)

337. Plutchik, Robert; Conte, Hope; and Landau, Herbert. A comparison of symptom evaluations by psychiatrists and social workers. *Hospital and Community Psychiatry*, 23(1): 13-14, 1972.

338. Pokorny, Alex D., and Bentinck, Catherine. A study of relatives' views of State mental hospital patients. *Social Casework*, 59(9): 519-526, 1969.

The views of relatives with respect to mental hospital patients' prospects for rehabilitation are compared with the objective condition of the same patients as determined by a detailed expert evaluation. A random sample of 1,537 patients, stratified by age, ethnicity, sex, and length of hospital stay, was drawn from current Texas State mental hospital patients. The patients were assessed by psychiatric interviews and ratings, physical examinations, laboratory tests, psychological tests, and social work interviews. Professionals were asked to make judgments regarding prognosis for each patient and to record their findings, diagnoses, and concrete opinions. A mail questionnaire was sent to patients' relatives, covering the prehospitalization life and behavior of the patient, the nature of the illness, the circumstances surrounding admission, the relatives' views of the patients' hospital treatment, and the relatives' attitudes toward possible placement,

rehabilitation, or release of the patient. Data for patients (1,214) whose questionnaires were returned by relatives were analyzed using cross-tabulation and Chi-square tests of significance. The major finding was that patients' relatives were less optimistic than professionals. Fifty-seven percent of the patients were viewed by the professional review panel as fit to be released, provided adequate alternative facilities and community programs could be found. Only 20 percent of the patients' relatives expect the patient to return home, and only 37 percent would welcome the patient if returned.

339. Polakow, Robert L., and Doctor, Ronald M. A. Behavioral modification program for adult drug offenders. *Journal of Research in Crime and Delinquency*, 11(1): 63–69, 1974.

A behavior modification program designed to deal with adult probationers is described. This contingency management program was compared to a regular caseload using traditional "counseling" methods. Caseloads were matched in several ways. The contingency management program involved three phases. In phase 1, the probationer received credit for prompt attendance, politeness, and serious discussion during a weekly meeting with the probation officer. After earning eight credits in 8 weeks or more, the probationer advanced to phase 2. Weekly group meetings were oriented toward experience, sharing discussion of problems, support for self-correction, and behavioral rehearsal. After earning 10 credits, phase 3 began with probationers negotiating a contract with the probation officer. Specific behaviors, detailed in the contract, could justify reductions in his probation time. Violations led to demotion to the first level. The mean number of probation violations per year for regular probation was .50 and .00 for contingency management. The mean number of arrests was .25 for regular probation and .18 for contingency management. The percentage of months employed was 52.5 for regular probation and 74.7 for contengency management. (9 references)

340. Post, Gene C.; Hicks, Robert A.; and Monfort, Mariam Felicia. Day-care program for delinquents: A new treatment approach. *Crime and Delinquency*, 14(4): 353–359, 1968.

341. Pumphrey, Muriel W.; Goodman, Mortimer B.; Kidd, John W.; and Peters, Edward N. Participation of retarded children in regular recreational activities at a community center. *Exceptional Children*, 36(6): 453–458, 1970.

342. Purvis, S.A., and Miskimins, R.W. Effects of community follow-up on post-hospital adjustment of psychiatric patients. *Community Mental Health Journal*, 6(5): 374–382, 1970.

The effectiveness of a vocationally oriented followup program upon hospital recidivism and vocational adjustment is studied,

using a sample of 152 discharged psychiatric patients. The results indicated that followup was better than no followup, and in a community-based followup program the patient was randomly assigned to one of three followup modes. Group followup was a weekly group meeting conducted by two vocational rehabilitation counselors. Control, or no followup, consisted solely of the periodic issuance of project research forms. An analysis of variance to determine the average days spent out of intensive hospital care in the period under study of each of the main groupings (group, individuals, and control) resulted in a nonsignificant difference ($F = 1.20$) among the means. The major followup modalities (Group, Individual, and Control) were found to differ significantly ($p < .05$) in the extent of their contact with the hospital. Subjects in the Group followup mode had the least hospital contact (35 percent), while the Individual and Control modes had higher and similar contact percentages (56 percent and 54 percent, respectively). The most active subgroups of the Group followup mode tended ($p. < .10$) to have less hospital contact than those in the Group followup mode who participated moderately or not at all. Both the Group and Individual followup modes showed higher vocational success than the control mode, but statistical significance was not reached.

343. Quick, Alton D; Little, Thomas L.; and Campbell, A. Ann. Early childhood education for exceptional foster children and training of foster parents. *Exceptional Children*, 49(3): 206–208, 1973.

344. Rada, Richard T.; Daniels, Robert S.; and Draper, Edgar. An outpatient setting for treating chronically ill psychiatric patients. *American Journal of Psychiatry*, 126(6): 789–795, 1969.

345. Rapler, Jacqueline; Adelson, Ruth; Carey, Richard; and Croke, Katherine. Changes in children's attitudes toward the physically handicapped. *Exceptional Children*, 39(3): 219–223, 1972.

346. Raskin, Marjorie, and Dyson, William L. Treatment problems leading to readmission of schizophrenic patients. *Archives of General Psychiatry*, 19(3): 356–360, 1968.

A study of events leading to readmission of mental patients is reported. Forty-five consecutively admitted schizophrenic patients who had at least one prior admission to the inpatient unit constituted the study group. Events leading to their readmission were reconstructed from interviews with the patient, family, and therapist, as well as from records. After readmission and subsequent discharge, the patient's clinical course was observed for 1 year. At the time of discharge from the hospital, prior to each patient's readmission, aftercare had been arranged for all 45 patients. However, at the time of the

patient's readmission, an average of 7 months later, only 14 patients (31 percent) were still in treatment. Sixteen of the 45 patients had never begun treatment, 11 patients had become involved in treatment but had "dropped out," and 4 patients had been discharged from aftercare. Readmissions of patients who remained in the aftercare program occurred for two main reasons: (1) a change of therapists, and (2) some patients are so lonely within the community that they cannot be maintained there despite aftercare. Twelve of the 16 patients who had not become involved in aftercare treatment had trouble adjusting to the community. Their readmissions usually occurred because of socially disruptive behavior. Hospitalizations of these 12 patients had often been terminated by the patient's running away or by their families' signing them out against advice. Not one of these 12 patients became involved in aftercare, and 6 in this group had a subsequent readmission during the followup period. Increasing hopelessness about the chronic difficulties of their lives was the primary reason cited by those patients who dropped out of aftercare prior to their readmission.

347. Rathbone-McCuan, Eloise, and Levinson, Julia. Impact of socialization therapy in a geriatric day-care setting. *The Gerontologist*, 15(4): 338–342, 1975.

348. Redfering, David L. Durability of effects of group counseling with institutionalized delinquent females. *Journal of Abnormal Psychology* 82(1): 85–86, 1973.

349. Reichenfeld, Hans F.; Caspo, Kal G.; Carriere, Lucy; and Gardner, R.C. Evaluating the effect of activity programs on a geriatric ward. *The Gerontologist*, 13(3): 305–310, 1973.

The development of a group-oriented activity program introduced on a psychogeriatric ward and an evaluation of its effects are discussed. This investigation took place at the London Psychiatric Hospital in London, Canada. The hospital is divided into four semi-autonomous units, each of which contains a geriatric ward. Admission to these wards is made on a rotational basis. None of the wards had a regular activity program. Initial nonstructured group therapy sessions were dropped due to lack of patient participation. Next a classroom-like setting was set up with the therapist as teacher at a blackboard facing a group of 10–12 patients selected by the group leader. The blackboard was used to provide visual stimulation and increase attention span. The group discussed a variety of topics ranging from listing types of fish to topical events. Interaction between group members became freer in this more structured setting. Reminiscing was encouraged as an adaptive strategy in the normal aging process. In the summer of 1970, leadership of the group was assumed by the nurse, who had

been observing; other activities were developed: daily physical exercises, weekly religious services, art therapy, and daily recreational activities. At the end of 1970, a study comparing wards A, B, C, and D with regard to discharge rates, status on discharge, level of functioning, and staff attitudes over a period of 2 years was conducted. Discharge frequencies were significantly higher for wards A and D. Upon discharge, patients were classified as improved, unimproved, or deceased. A Chi-square analysis revealed that Ward D had a disproportionately greater number of "improved." Ward A was higher than expected in the "unimproved" category. Wards B and C showed a disproportionately higher number of cases in the "deceased" category. Ratings indicated that the patients on all four geriatric wards were unable to look after themselves, had a high degree of organic mental impairment, were depressed and apathetic, and had limited mobility. Ward D, though, had the least amount of behavioral deterioration. Findings confirm that activity programs are correlated to higher discharge rates. (24 references)

350. Reid, William J. A study of caseworkers' use of insight-oriented techniques. *Social Casework*, 48(1): 3-9, 1967.
351. Remnet, Valerie L. A group program for adaptation to a convalescent hospital. *The Gerontologist*, 14(4): 336-341, 1974.
352. Rice, Dale L., and Semmelroth, Sara. Foster care for emotionally disturbed children. *American Journal of Orthopsychiatry*, (38(3): 539-542, 1968.
353. Richardson, Stephen A. Age and sex differences in values toward physical handicaps. *Journal of Health and Social Behavior*, 11(3): 207-214, 1970.
354. Richardson, Stephen A. Children's values and friendship: A study of physical disability. *Journal of Health and Social Behavior*, 12(3): 253-258, 1971.
355. Riehman, Lynne, and O'Brien, Carolyn F. Project in apartment group living. *Social Work*, 18(3): 36-43, 1973.

Described is a program for community group living for a State mental hospital's former patients. The project team consisted of two social workers, a social work supervisor, a psychiatrist, and an attendant. The project team was responsible for selection of patients, referral to community services, prescription of medication, weekly group meetings to discuss problems in apartment group living, and counseling for personal problems. Ex-patients chosen were age 21 to 50, were not abusing alcohol, and showed a tolerance for group living. In August, 1969, six male ex-patients who had been hospitalized for 10-30 years moved into an apartment in West Manhattan. One month later, six females, four hospitalized for the first time

and two with intermittent hospitalization over 10 years, moved into an adjacent apartment. Group therapy was the main treatment method. Residents participated in the screening and selection of new applicants. Up to January 1972, the program had a total of 35 residents—19 males, 16 females. All the men and 14 women were diagnosed as schizophrenic; one woman was diagnosed as manic-depressive, and one had a depressive neurosis. Of these 35, seven men and seven women were rehospitalized; eight remained in the hospital and six later returned to the community to live alone or with friends or family. Twenty-one of the 35 residents continued to live without interruption in the community. Ten of the 35 residents moved directly from the program to jobs, to return to their family, or to live alone or with friends.

356. Ring, Stephen I., and Schein, Lawrence. Attitudes toward mental illness and the use of caretakers in a black community. *American Journal of Orthopsychiatry*, 40(4): 710–716, 1970.

A survey of mental health attitudes and caretaker utilization in a lower-middle income black community in West Philadelphia is presented. Interviews were held with a "responsible respondent," meaning a husband, wife, adult offspring, or other adult member of the household in 388 households. Responses to a series of attitudinal items on mental illness showed that respondents agreed strongly with items representing a positive mental health outlook and disagreed strongly with items representing a negative view. Respondents, reacting to selected social distance items, were agreeable to associations with ex-patients beyond the immediate household, but not within the immediate household. Nearly 90 percent of respondents indicated they would use medical personnel if faced with a mental or emotional problem; only 30 percent anticipated clergy as a resource, and less than 2 percent would turn to family and friends. Of the 388 household, 223 (58 percent) reported one or more members with one or more psychological problems. One half of these 223 reporting problems reported seeking help. A physician was contacted 85 percent of the time; less than 40 percent used nonmedical professional caretakers. The authors concluded that the community mental health center in the survey area should develop a strong relationship with neighborhood medical practitioners.

357. Roberts, Alan H.; Erikson, Robert V.; Riddle, Mary; and Bacon, Jane G. Demographic variables, base rates, and personality characteristics associated with recidivism in male delinquents. *Journal of Consulting and Clinical Psychology*, 42(6): 833–841, 1974.

All first admissions to a treatment facility for delinquents (N= 455) were evaluated. Of these, 395 could be classified as

recidivists or nonrecidivists. Recidivism rates increased as a function of the length of time since release. Significantly higher rates of recidivism were found among the younger delinquents, ($p < .001$), those previously institutionalized ($p < .005$), and those who had previously run away from an institution ($p < .005$). Intelligence, length of stay at the facility, ethnic group, rural versus urban residence, marital status of parent, cottage residence at facility, and offenses committed were not significantly related to recidivism. A second study collected followup data on 20 male delinquents who had been released from the treatment facility for 13 to 34 months. Recidivists and nonrecidivists did not differ from each other with respect to the boys' age, length of stay at the time the data were gathered, or length of stay at the time of discharge. The two groups did differ from each other on measures of foresight and planning ability and impulse control. A third study replicated and extended the second study using a sample size of 68 male delinquents. There were no significant differences with respect to ethnic group, previous institutionalizations, or foresight and planning ability. However, impulse control, as measured by the Porteus Q score, differentiated among the groups.

358. Roen, Sheldon R.; Ottenstein, Donald; Cooper, Saul; and Burnes, Alan. Community adaptation as an evaluative concept in community mental health. *Archives of General Psychiatry*, 15(1): 36–44, 1966.

359. Rog, Dennis J., and Raush, Harold L. The psychiatric halfway house: How is it measuring up? *Community Mental Health Journal*, 11(2): 155–162, 1975.

Effectiveness of halfway houses is assessed by tabulating 26 outcome studies. Halfway house programs are defined as programs aimed at ex-inpatients or potential inpatients. Wide variation in definition exists among the 26 studioes. Average length of stay ranged from 15 to 30 months, selectivity of intake differed, and time from discharge to followup varied from 0 to 4 years. The three main criteria for program effectiveness were proportion working or in school, proportion living independently, and proportion subsequently hospitalized. An overview of the 26 studies indicates that on followup about 20 percent of halfway house residents were hospitalized, while over half continued working or remained in school. The results may be assessed as mildly encouraging.

360. Rogoawski, Alexander S., and Edmundson, Betty. Factors affecting the outcome of psychiatric interagency referral. *American Journal of Psychiatry*, 127(7): 925–934, 1971.

Reported is an analysis of rate of completion of referrals for all patients referred during an 8-week period from the admitting-evaluation unit of a psychiatric inpatient services unit of a large

university medical center to outpatient services and community agencies. Rate of completions were correlated with data about the referring professional and the referral technique, and data about the receiving agency. A referral was considered completed when the patient was evaluated by the receiving agency and kept his first two appointments. Of 385 referred patients, data were obtained on 334. Forty-two percent completed the referral during the time of the study. The completion rate was doubled if contact with the receiving agency was initiated by a phone call from the referring professional. When the referring professional established rapport with the patient, the completion rate was also significantly improved. The policies and attitudes of the receiving agency were factors of next importance. Private practicing psychiatrists did much better than either public or private agencies. Patient-related factors (age, sex, race, income, etc.) played the least important role in the referral outcome. The only patient-related factor approaching significance was a history of previous contact with tne psychiatric unit of the medical center. For distances up to 25 miles between the receiving agency and the patient's home, the patient's willingness to complete the referral did not seem to be appreciably affected by distance.

361. Rosenhan, D.L. On being sane in insane places. *Science 179;* 250–528, January 1973.

Experiences of eight persons who posed as patients in 12 mental hospitals, for an average of 19 days each, are recounted. Staff did not notice that the "pseudo patients" were not mentally disturbed, although patients often did. The experience of being labeled, powerless, and depersonalized was more disturbing than the volunteers had expected, and many acted in ways to assert their personality or to get out of the institutions quickly. Three factors are identified as being some of the mechanisms for depersonalization: (1) public fear and distrust toward mentally ill or those so labeled; (2) staff avoidance of interaction with mental patients; for six of the hospitalizations where records were kept, total daily contact with psychiatrists, psychologists, residents, and physicians in any context averaged 7 minutes; (3) organizational practices such as excessive record-keeping and staff meetings, and narcotherapy, which are judged more important than fiscal restraints.

362. Rouse, Bobbye M., and Farb, Joel. Training adolescents to use behavior modification with the severely handicapped. *Exceptional Children* (40(4): 286–287, 1974.

363. Rowden, David W.; Michel, Jerry B.; Dillehay, Ronald C.; and Martin, Harry W. Judgments about candidates for psychotherapy: The influence of social class and insight-verbal ability. *Journal of Health and Social Behavior*, 11(1): 51–58, 1970.

The influence of patients' social class, patients' insight-verbal ability, and therapists' social class origins on therapists' judgments regarding the use of psychotherapy as a treatment modality is investigated. Practicing and trainee therapists (34) were asked to make judgments for or against psychotherapy for 10 hypothetical patients on the basis of written case histories. The case histories were designed to control for all important variables, except the patient's insight-verbal ability and social class, which were systematically manipulated. The results indicate that high patient social class and high insight-verbal ability increase the probability of selection for psychotherapy, with some evidence that the latter factor is more important. (12 references)

364. Rubington, Earl. Alcoholic control on Skid Row: Preliminary draft of a research and demonstration proposal. *Crime and Delinquency*, 13(4): 531-537, 1967.
365. Rucker, Chauncy N.; Howe, Clifford E.; and Snider, Bill. The participation of retarded children in junior high academic and nonacademic regular classes. *Exceptional Children*, 35(8): 617-623, 1969.
366. Sabagh, George; Lei, Tzuen-Jen; and Eyman, Richard K. The speed of hospitalization revisited: A replication of a study of a preadmission cohort in a hospital for the retarded. *Social Problems*, 19(3): 373-382, 1972.

An earlier study of the determinants of the speed of admission to a State hospital for the retarded is replicated. Two samples were compared. Data for both 1960-61 and 1965-66 samples included data on patient characteristics, handicaps, and family attributes from standard hospital admission forms. For the 1965-1966 sample, data were also available on parents' attitudes toward institutionalization and parental opinions on the possible effect of hospital placement on the patient. Statistical analyses showed a dramatic change over a short number of years in the variables that differentiate admissions from nonadmissions. The degree of retardation became the primary consideration for admission in the 1965-1966 sample, in contrast to family income which appeared to be most predictive in the 1960-1961 sample. Increased community services for the retarded apparently have changed determinants of admission.

367. Safier, Ruth. Homemakers for the chronically ill and aged: A description. *The Gerontologist*, 6(3): 150-153, 1966.
368. Salomone, Paul R.; Lehmann, Elizabeth; and Green, Alan J. Occupational exploration practices: A pilot study to increase the vocational sophistication of slow learners. *Mental Retardation*, 1973.
369. Salter, Carlota de Lerma, and Salter, Charles A. Effects of an individualized activity program on elderly patients. *The Gerontologist*, 15(5): 404-406, 1975.

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370. Saltz, Rosalyn. Aging persons as child-care workers in a foster-grandparent program: Psychosocial effects and work performance. *International Journal of Aging and Human Development*, 2(4): 314-340, 1971.

371. Salvia, John; Clark, Gary.; and Ysseldyke, James E. Teacher retention of stereotypes of exceptionality. *Exceptional Children*, 39(8): 621-626, 1973.

372. Sandall, Hilary; Hawley, Timothy T.; and Gordon, Gloria C. The St. Louis Community Homes Program: Graduated support for long-term care. *American Journal of Psychiatry*, 132(6): 617-622, 1975.

The St. Louis Community Homes Program is described; alternative living environments are provided for ex-mental hospital patients. The program placed long-term chronic patients in minimally supervised group-living apartments. Between May 1971, and April 1974, 151 patients had been placed in apartments. Most of them had been long-term psychiatric patients with a mean length of previous hospitalization of 6.5 years. Of these 151 patients, 87 were in residence during the month of April 1974, when this study was taken. Thirty had moved either to places that they rented themselves, to live-in jobs, or back to their original families. Forty-two residents who required more supervision had moved back to the hospital or to a nursing or boarding home. Length at previous hospitalization was the only significant predictor of moving to a more or less independent situation. Length of previous hospitalization, however, did not predict degree of adjustment to the program.

373. Santore, Anthony F., and Famond, Herbert. The role of a community mental health center in developing services to the aging: The older adult project. *The Gerontologist*, 14(3): 201-206, 1974.

A report on a multifaceted program for the elderly population in southwest Philadelphia is presented. The Older Adult Project was an integrated program of casework, community action, and comprehensive planning, designed to improve services for older residents in the community. A small grant for a 10-week pilot project made possible the screening, recruitment, and hiring of eight senior case aides from the area who proved to be invaluable. All aides over 60 were paid $2.20 per hour, worked 20 hours per week, and received inservice training. During this 10-week period, a caseload of 162 was developed, and a senior citizens' club was founded. After 10 weeks, the CMHC decided to continue support for the program and invested $17,481 between July 1971 and July 1972. A storefront facility, opened in September 1971, became a center for crisis intervention, referral, information, and staff training.

Caseload grew to 259 with the continued development of transportation, a crafts shop, a drop-in center, and two senior citizen clubs. An Emergency Home Visiting Team was developed to offer crisis intervention in the homes of the aged. The need for medical transportation services became apparent as it rose from 9.6 percent of client contacts to 35.3 percent in 12 months. As of August 1973, the caseload was 212. Between January 1, 1973 and June 30, 1973, 500 different individuals participated in the two senior citizens' clubs, Sunday dinners, craft shop, trips, and the weekly drop-in hot lunch program. A Community Older Adult Board was founded to represent the consumers of the service and to assist in program planning and policy guidance.

374. Santostefano, Sebastiano, and Stayton, Samuel. Training the preschool retarded child in focusing attention: A program for parents. *American Journal of Orthopsychiatry*, 37(4): 732-743, 1967.

A training program devised to promote focal attention in preschool retarded children and administered at home by the children's mothers is presented. It was hypothesized that if focal attention or ability to fully attend to an object long enough to comprehend its unique properties is an ego function active in the operation of higher functions, then training in focal attention would result in increasing the efficiency of higher cognitive functions. Thirty-one mothers and their severely to moderately retarded children (17 boys and 14 girls with age range from 3.5 to 7.8 years) participated in the program. Thirty-two control children (16 boys and 16 girls with age range from 3.9 to 7.3 years) were selected from four nursery school programs. The focal attention training program of 4 months had 22 main levels, each with six sublevels, representing a progressive increase in complexity of information to be processed by the child. With each sublevel, a prescribed display of magnetized cutouts was placed on a green magnetic board by the mother. The child's task was to remove particular cutouts on the board. If a child failed to respond, the mother was instructed to guide the child's hands through the correct response. Mothers conducted the training 10-20 minutes every day. The experimental and control groups showed similar ability on tests before the home training period. On all tests except the body imitation test, the experimental children showed a greater increase after home training (.05 level). After home training, the experimental group showed a greater capacity to understand and use guidance (.05 level).

375. Sarason, Irwin G. Verbal learning, modeling and juvenile delinquency. *American Psychologist*, 23(4): 254-266, 1968.

376. Sarata, Brian P. Employee satisfactions in agencies serving retarded persons. *American Journal of Mental Deficiency*, 79: 434, 1975.

The work satisfactions of individuals employed by three agencies serving retarded persons are reported. Satisfaction with the specific agency appears to be the chief determinant of overall employment satisfaction. Questionnaires were completed by 222 employees of three State agencies mandated to provide comprehensive services to the retarded. Overall satisfaction with employment is most closely related to agency-related matters. Those employees with high-level client contact who cited client-related sources of dissatisfaction seemed to attribute their feelings of dissatisfaction to the agency. Those employees with a high level of agency dissatisfaction viewed lack of client progress as some fault of the staff or the agency rather than limited progress as inevitable.

377. Sauber, Mignon. Replacement situations of families: Data for planning services. *Child Welfare*, 46(8): 443-449, 1967.

378. Scheff, T.J. The labelling theory of mental illness. *American Sociological Review*, 39(3): 444-52, 1974.

The labeling theory of mental illness is defended. Eighteen studies which relate to labeling theory are reviewed, with the conclusion that 13 are consistent with labeling theory. It is stated that the theory is perhaps ambiguous, ideologically biased, and not literally true as some critics have claimed. But labeling theory was meant to dispel confusions arising from the medical model and to be a sensitizing theory, and therefore may be useful despite shortcomings. In the review of research, studies were included which were found to be systematic and to relate explicitly to labeling theory. Of the 18 selected, 13 "support," that is, are consistent with, labeling theory. Findings consistent with labeling theory include a finding that mental hospital commitment rates are higher for blacks than whites; that family's desire for release is associated with released; that commitment rates are associated with a variety of signs of powerlessness; that psychiatrists and psychologists seemed amenable to suggestion in finding mental illness; and finally, that normal people live in mental hospitals as patients without being detected. Findings inconsistent with labeling theory include interview evidence that ex-patients do not report acceptance of deviant role or stigma; that a long-term followup did not find more adult "sociopathology" among persons receiving treatment in childhood; and that greater resources were used to obtain treatment than to avoid it.

379. Schroder, David, and Ehrlich, Danuta. Rejection by mental health professionals: A possible consequence of not seeking

appropriate help for emotional disorders. *Journal of Health and Social Behavior*, 9(3): 222-232, 1968.

380. Schulberg, Herbert C. The mental hospital in the era of human services. *Hospital and Community Psychiatry*, 24(7): 467-472, 1973.

The argument is presented that, in the future, mental hospitals will either become general human service resource centers or will be phased out. The present tendency to conceptualize "human service" as covering social, personal, and community problems and to create comprehensive systems of service is expounded. The necessity of community participation is recognized. The logical outcome of these various trends is to transform the mental hospital to a center where programs as diverse as detoxification, daycare, and chronic care would be housed, but where the professional and technical skills needed for a comprehensive human service system would also be located. One possibility for financing would be sale of specific services to community-based boards administering tax funds.

381. Schwartz, Marc D. Situation/Transition groups: A conceptualization and review. *American Journal of Orthopsychiatry*, 45(5): 744-755, 1975.

Experience with situational transition (S/T) groups is summarized. As to target groups and purpose, S/T groups are organized to help the ill, members of disorganized families, unemployed, and persons in other stress situations. Focus of S/T group interaction is not on personal change. Five to 12 persons meet 1 or 2 hours per week for 4 to 15 weeks, with a professionally trained leader. Methods of help include social support, information about the problem situation, and emotional interaction around the problem situation. Matters of religion, personal philosophy, and personal style are avoided. Three particularly helpful factors emerge: First is an experience of security, mutual support, and suppression of the unpleasant. Second is the opportunity to express feelings. Third is factual or instrumental clarification. The literature includes a number of reports of positive effects with various target groups, indicating a potential for mental health prevention. Certain problems with S/T groups should be noted. One is the problem of discouraging recruits by use of mental health labels. Another is the problem of the leader in directing "treatment," when ascribed power of the leader is low. A third is the danger of permitting the group to move into personal or emotional, as against situational, concerns.

382. Schwitzgebel, Robert L. Short-term operant conditioning of adolescent offenders on socially relevant variables. *Journal of Abnormal Psychology*, 72(2): 134-142, April 1967.

The effectiveness of a series of interviews with an operant-

conditioning orientation in developing desirable social behavior in juvenile delinquents is examined. The subjects (48) were adolescent male delinquents recruited informally from street corners. Each subject was paid to take part in the interviews and was assigned to one of three matched groups: two experimental and one control. Those assigned to the experimental groups (21) participated in 20 interviews over a period of 2-3 months, in which they were differentially treated on four classes of operants: hostile statements, positive statements, prompt arrival at work, and general employability. Experimental group I (9) received positive consequences, e.g., verbal praise or small gift for statements of concern or positive statements about other people and for dependable and prompt arrival at work. Experimental group II (12) received negative consequences, e.g., disagreement or inattention for hostile statements about people and positive consequences for socially desirable nonverbal behavior. The control group (14) participated in only two interviews over the 2-3 month period. The main task for each of the program participants during a work session consisted of talking into a tape recorder about anything they wished 2 to 3 times per week for 1 hour in the presence of the experimenter who reinforced desirable behaviors. Statistical analysis of the data obtained by observation of the delinquent's behavior at the beginning and at the end of the interview program indicates that there was significant increase in the frequency of desirable behaviors followed by positive consequences. Attempted punishment of hostile statements resulted in no significant decrease in undesirable behavior. (25 references)

383. Scott, Robert A. The factory as a social service organization: Goal displacement in workshops for the blind. *Social Problems*, 15(2): 160–175, 1967.

A process of goal displacement and subsequent change in professional ideology is described among managers of sheltered workshops for the blind from the 1930s through the 1950s. The original purposes of workshops for the blind were to provide a social service, to be laboratories for training, and to absorb blind workers who were competent but could not find jobs. There were three factors which doomed the social service goals on a logical basis: (1) Deficit operation is inevitable for a social service, but no source of funding the deficit was available; (2) the workshops were exposed to marketplace constraints, such as a low and declining demand for brooms and mops; (3) competent industrial managers, needed to set up the workshops, did not share social service orientations. The actual history of the workshop movement during the Depression is outlined, showing how the service goals were displaced and how workers

accommodated to the new situation by changing their ideology rather than their goals or methods. The Wagner-O'Day Act of 1937 gave the workshops a guaranteed market. To meet the higher demand, criteria for workers quickly moved from welfare criteria to production criteria such as youth, partial sight, dependability, and the like. From 1940–1943, the monopoly of government business plus war-related business combined to equal over 25 million per year. Two basic changes in ideology accommodated these changes in program. First, as shown in Proceedings of the American Association of Workers with the Blind, the idea that blind workers should have their own work places was increasingly supported. Second, the idea that the public in general and employers in particular were ignorant and unsympathetic about blindness was increasingly adopted.

384. Segal, Arthur. Workers' perceptions of mentally disabled clients: Effect on service delivery. *Social Work*, 15(3): 39–46, 1970.

A survey taken to determine the obstacles to the delivery of social services to mentally disabled adults is described. Fifty-six adults were drawn from the caseload of Aid to Permanently and Totally Disabled recipients in a California welfare department. Of the 29 men and 27 women, 43 were diagnosed as mentally retarded, 9 as schizophrenic, and 4 as physically disabled; only 38 were willing to be interviewed. The 5 caseworkers for these 38 subjects were interviewed individually to determine the caseworkers' awareness of their clients' daily activities and rehabilitation needs. A comparison of clients' responses and workers' responses to the same questions showed that the workers had no knowledge of the activities of most clients, they had incomplete knowledge of their clients' solitary recreational activities, and they lacked awareness of their clients' performance of household chores. A comparison between workers' expression of their goals for their clients and the clients' desires showed that both groups see employment as important, that workers place a far greater importance on recreation and home management as goals, that clients saw education as an important goal and workers did not. A review of case materials indicated 18 adequate and 18 inadequate psychological reports, 13 records citing a diagnosis of mental retardation with no psychological evaluation, and four adequate and six inadequate psychiatric evaluations. Findings seemed to indicate that workers had a poor basis for understanding and planning with their clients.

385. Serban, George, and Thomas, Alexander. Attitudes and behaviors of acute and chronic schizophrenic patients regarding ambulatory treatment. *American Journal of Psychiatry*, 131(9): 991–995, 1974.

Relations between the use of services by schizophrenic ex-mental hospital patients and their opinions regarding the value of medication, outpatient care, and employment are studied. The study population consists of 641 schizophrenics; 80.5 percent (N = 516) were chronic, and 19.5 percent were acute cases. Acute cases were defined as without previous hospitalization. Of the 349 chronic and 70 acute patients who were available to the followup, 258 (73.9 percent) chronic and 31 (44.3 percent) acute patients were readmitted in the course of the 2-year followup. On admission and readmission, clinical psychologists gave the subjects a battery of tests related to their mental status, ability at problem appraisal, motivational orientation, personality and psychosocial functioning, and stress. Twenty-eight questions relating to the patient's attitudes toward medication, aftercare, employment, welfare, and hospitalization were analyzed to identify five nonoverlapping attitudinal dimensions. Results indicated an extreme noncompliance with the use of drugs by chronic patients; of 516 chronic patients, 41.9 percent reported nonuse of prescribed medications between hospitalizations, though 67.8 percent believed regular medication would be helpful. Attitudes toward professional aftercare revealed a similar trend for attitudes toward employment versus welfare. There was less discrepancy between behavioral manifestation and attitudes. Attitudinal statements of the followup chronic patients (N = 349) showed that nonuse of prescribed medication, nonuse of outpatient services following hospitalization, and reliance on welfare assistance were all highly associated with readmission. Discriminant functional analysis using medication, clinic attendance, and employment history correctly identified 78.5 percent of the cases as to their actual readmission status. Unemployment and welfare assistance ranked as the two most discriminating of the variables.

386. Severn, Marion, and Mendelson, Lloyd. Characteristics of family caretakers. *Hospital and Community Psychiatry*, 20(8): 245-247, 1969.

The psychosocial characteristics of caretakers is studied through the use of the California Psychological Inventory (CPI). The CPI is divided into 18 scales concerned with personality characteristics that are important for social living and social interaction. The scales are divided into four broad classes that represent psychological clusterings. Prior to administering the CPI to the caretakers, the social workers with whom the caretakers worked evaluated each caretaker's performance as being most satisfactory, less satisfactory, and least satisfactory. One hundred-forty of 250 caretakers completed the CPI. Mod-

erately significant relationships were found with the social worker's performance rating of caretakers for these variables. "Sociability" and "self-acceptance" related positively to good ratings, whereas "social presence" related negatively. The effective caretaker seems to be an outgoing, self-accepting, tolerant person, poised and resourceful in dealing with others, but not given to dominating or exploiting them.

387. Shapiro, Alex. A pilot program in music therapy with residents of a home for the aged. *The Gerontologist*, 9(2): 128–133, 1969.

388. Shapiro, Joan. Dominant leaders among slum hotel residents. *American Journal of Orthopsychiatry*, 39(4): 644–650, 1969.

The quality of group life in New York City "single-room-occupancies" (SROs) and the role of indigenous leaders who help and protect others are portrayed. The basis for the report was community work by the community psychiatry staff of St. Luke's Hospital with six SROs housing 80–120 alcoholics, addicts, ex-mental hospital patients, ex-prisoners, elderly chronically ill, disabled, and single transients. At least 30,000 New York residents live in such hotels. Populations of the hotels were up to two-thirds male, 60 percent black; two-thirds or more had a major chronic disease or disability, and virtually all exhibited serious social or psychiatric problems. Ties to family or community institutions were absent. Residents spend most of their time in the immediate vicinity of the SRO, and their lives are marked only by the biweekly arrival of the welfare checks. After living expenses and binges, residents get along on about $10 per week. Despite marginal status of all, most residents joined one or more cliques for socializing and support. Many leaders of cliques were exploitive and even sadistic. Among the six SROs, however, were three women known to all residents as expressive, outgoing, and a source of help and gratification. These women were all black, age 40–55, alcoholic and chronically ill, and had more education (high school) than other residents. The women helped residents get direct oral gratification, e.g., through collections of cigarette butts; they helped control and monitor deviant behavior; and they mediated between deviating individuals and other residents or community agents. The St. Luke's team social workers assigned to work in SROs were at first competitive, then collaborative, with the three women. It appears that mental health workers should seek such indigenous "caring" persons in disorganized settings and perhaps emulate their behavior to some extent.

389. Shean, Glenn. An effective and self-supporting program of community living for chronic patients. *Hospital and Community Psychiatry*, 24(2): 97–99, 1973.

A self-supporting group of female ex-mental patients living and working in the community of Williamsburg, Virginia, according to the Fairweather Task-group concept, is described. A nonprofit charitable corporation was formed in 1969 with a board of local leaders. Nine or 10 women at a time, or a total of 25 in the first 3 years, lived together in a rented house and shared household duties. The corporation contracted their services to employers and paid allowances to the women, medical care, all living expenses, and cost of employment. Only three of the first 25 women had been readmitted to hospital. The program began with a $10,000 loan and a $10,000 subsidy from the State. After 2 years, the program became self-supporting. Of the first 25 women members, the mean age was about 40, and the mean total hospital residency was about 6 years. One problem was motivating patients to learn new skills and prepare to leave the hospital when most employers would consider them for only menial work. These factors were offset by the attractive residence and enthusiasm of residents.

390. Shears, Loyda M., and Jensema, Carl J. Social acceptability of anomalous persons. *Exceptional Children*, 36(2): 91-96, 1969.

391. Sherman, Susan P. Provision of on-site services in retirement housing. *International Journal of Aging and Human Development*, 6(3): 229-247, 1975.

The provision of and satisfaction with onsite services at six widely varying retirement housing sites in California is studied, based on data from interviews with 600 residents. The six sites represent the most typical kinds of retirement housing in California. One hundred residents were selected at each site through systematic probability sampling. The average age at four sites was 75, with widows and other single women predominant. Mostly married couples, averaging 68 years of age, lived at the other two sites. Comparative data were analyzed for matched controls living in the community. The control group are assembled from a pool of names provided by a market research study. Tests and controls were matched on sex, working status, marital status, age, and income, among others. The interview covered medical and counseling services as well as the amount of support expected in crises. Respondents were asked to give a self-rating on health and to respond to a checklist of health problems. There were no significant test-control differences. In response to whether or not their health needs were easy to care for, respondents—both control and test—answered similarly in all but one site, where there were many complaints about medical care. The sites were uniform in the number of respondents thinking counseling services were needed (40 percent

said yes), with the exception of the site that felt their health needs were inadequately met. At this site, 70 percent of the respondents saw a need for counseling services. The site residents were asked if it would be easier to cope with four serious personal crises (major finances problem, trouble with family, serious illness or disability, and death of a loved one) at the site or at their former residence. Respondents at three sites felt they would cope better at the site, respondents at the site that was significantly different in the former questions expected the least support at the site, and respondents at the other two sites were intermediate. Approximately three-fourths of the controls thought it would be easier to cope with such crises in their present residence. There is no evidence of erosion of independence at the sites where services are provided. (25 references)

392. Shin, H. Joo, and Kerstetter, Wayne A. The Illinois experience: Arrest rate changes after methadone-centered multi-modality treatment. *Journal of Research in Crime and Delinquency*, 10(2): 163-176, 1973.

Self-reported and official arrest records of the 772 patients who participated in the Illinois Drug Abuse Program between May 26, 1969 and April 26, 1970 are analyzed to examine changes in arrest rates. The program's primary treatment was methadone maintenance but included peer-group therapy, medical services, and supportive social services. In 1971, the program had 21 clinics with a patient populations of 1,600. Self-reported arrest data were significantly correlated with official arrest data. Using arrest per man-week, a 43 percent decrease of arrest rates for the period following admission was found for the 772 patients based on self-reports. Patients participating in the program for less than 10 weeks had smaller rate reduction (10 percent) than participants of more than 10 weeks (at least 44 percent). There was a greater reduction in arrest rates for male participants, for those who identified themselves with a religion, for those with less than a 12th grade education, for those with some kind of job skill, for those who began drug use at or before age 20, for those with four or more abstinence experiences, for those who preferred drugs other than heroin, and for those with current usage of more than 10 months. Individuals who had used drugs for 5 to 10 years had greater reduction rates than the group with less than 5 years of use and the group with more than 10 years of use. Using official records, the rate of reduction in man-week arrest rate from the 2-year period before admission was 62 percent. The highest reduction in arrest rate by crime was for vice crimes, then for narcotics offenses, then for crimes against property. (17 references)

393. Shotel, Jay R.; Iano, Richard P.; and McGettigan, James F. Teacher attitudes associated with the integration of handicapped children. *Exceptional Children*, 38(9): 677-683, May 1972.

394. Shyne, Ann W.; Sherman, Edmund A.; and Phillips, Michael H. Filling a gap in child welfare research: Service for children in their own homes. *Child Welfare*, 51(9): 562-573, 1972.

395. Sigelman, Carol K. A machiavelli for planners: Community attitudes and selection of a group home site. *Mental Retardation*, 1976.

396. Silberstein, Richard M; Mandell, Wallace; Dalack, John D.; and Cooper, Allen. Avoiding institutionalization of psychotic children, *Archives of General Psychiatry*, 19(1): 17-21, 1968.

397. Silverman, Wade M., and Val, Edwards. Day hospital in the context of a community mental health program. *Community Mental Health Journal*, 11(1): 82-90, 1975.

398. Simmons, Gladys; Gumpert, Joanne; and Rothman, Beulah. Natural parents as partner in child care placement. *Social Casework*, 54(4): 224-232, 1973.

A program (Family Residential Center) devised as an alternative to the placing of children in foster homes is described. The program utilized two connected apartments in a housing project for a small number of children to live together under the supervision of houseparents. Parents of children had almost unlimited visiting privileges and shared with the agency the responsibility for the care of their children. Parents attended parent group meetings and helped buy clothing and plan field trips. Treatment included individual and group therapy recreation, tutorial service, and summer camping. Treatment goals were to increase children's understanding of their parents, decrease their frustrations and anger, and develop appropriate social behavior. Comparison of the six black families who participated in the program with two control groups of nonparticipants indicated that the program fostered child-natural parent contact and that the children in the program more closely identified with their natural parents.

399. Simon, Stanford H.; Heggestad, Wayne; and Hopkins, Joseph. Some factors relating to success and failure of male chronic schizophrenics on their first foster home placement. *Community Mental Health Journal*, 4(4): 314-318, 1968.

The hospital records of 102 male chronic schizophrenics, who were placed for the first time in foster homes between November 1961 and June 1963, have a primary diagnosis of schizophrenia, did not have a diagnosis of chronic brain syndrome, were not returned to the hospital for physical reasons,

and had been hospitalized a minimum of 1 year prior to starting in a foster home, were examined in an attempt to uncover variables relating to the success and failure of patients placed in foster care. Success was defined as completing 11 months on foster care. Of the 102 patients examined, 77 were classified as successful, and 25 as failure. The success patients tend to be significantly older when first hospitalized ($r = .32$, $p < .02$), have a shorter period between first hospitalization and placement in a foster home ($r = .31$, $p < .05$), and have fewer admissions to the hospital ($r = .32$, $p < .02$). All three variables are or are nearly independent of each other.

400. Skipper, James K. Jr., and Leonard, Robert C. Children, stress and hospitalization: A field experiment. *Journal of Health and Social Behavior*, 9(4): 275-287, 1968.

401. Slickney, Patricia, and Cupaiuolo, Anthony. From CRISP: Strategies for community residences. *Child Welfare*, 55(1): 54-58, 1976.

402. Smith, I. Leon, and Greenberg, Sandra. Teacher attitudes and the labeling process. *Exceptional Children*, 41(5): 319-324, 1975.

403. Smolen, Elwyn M., and Lifton, Norman. A special treatment program for schizophrenic children in a child guidance clinic. *American Journal of Orthopsychiatry*, 36(4): 736-742, 1966.

404. Smyer, Michael A.; Siegler, Ilene C.; and Gatz, Margaret. Learning to live in a therapeutic community: A study of elderly inpatients. *International Journal of Aging and Human Development*, 7(3): 231-235, 1976.

A newly established geriatric milieu therapy unit in a State hospital is studied to find factors relating to the outcome status of the participants after a 9-month period. This study was a test of the relative importance of the unit's goals and philosophy, which emphasized community participation, as compared to staff members' implicit norms, emphasizing behaviors of a "good patient." When the unit opened, 105 patients age 65 or older were referred, 52 of whom were accepted onto the unit. After 9 months, three outcome groups were identified: discharged from the hospital (9); remained on the unit (32); returned to former wards (11). Behavioral norms related to nonpatient roles, including working regularly, signing in and out of the ward, and home visits, were measured. Staff ratings were made of patient's social behavior, liking for patients, and patient's progress. Measures of nonpatient role behavior were less salient than staff evaluations in accounting for patient outcome. Apparently the norms which had evolved at the end of 9 months were largely dictated by the staff's previous experience. To fully implement a mileu-therapy program, then, it may be

necessary to develop staff appreciation of individualized patient approaches. (5 references)

405. Spence, Donald L.; Cohen, Stewart; and Kowalski, Claire, Mental health, age, and community living. *The Geronotologist*, 15(1): 77-82, 1975.
406. Spivak, Mark. A conceptual framework for structuring the housing of psychiatric patients in the community. *Community Mental Health Journal*, 10(3): 345-350, 1974.
407. Stabler, Brian; Gibson, Frank W.; Cutting, D. Scott; and Lawrence, P. Scott. Zone planning for accelerating adaptive behavior in the retarded. *Exceptional Children*, 40(4): 252-257, 1974.
408. Stark, Heman G. Alternatives to institutionalization. *Crime and Delinquency*, 13(2): 323-329, 1967.
409. Stein, Leonard I.; Test, Mary Ann; and Marx, Arnold T. Alternative to the hospital: A controlled study. *American Journal of Psychiatry*, 132(5): 517-522, 1975.

Initial results are given of a clinical research program designed to help mental patients acquire the coping skills and autonomy necessary for a reasonable community adjustment. All adult patients seeking admission to Mendota Mental Health Institute for inpatient care with a diagnosis other than severe organic brain syndrome or primary alcoholism were included in the study. Eligible patients were randomly assigned to either the experimental community treatment group or a control group. Control group patients were treated in the hospital for as long as deemed necessary and then linked with appropriate community agencies. It was not a custodial hospital; the median length of stay was 17 days. Patients in the experimental group participated in a schedule of daily living activities, leisure activities, and training in social skills. The typical subject was relatively young, single, separated, or divorced and had accumulated a substantial amount of time in psychiatric institutions before admission to this study. Only 6 of the 60 experimental patients were hospitalized, in comparison with 54 of the 60 control patients. Of the 54 control patients who were hospitalized, 14 were readmitted after being discharged within the first 4 months of the study. There was no significant difference between the groups in the amount of time spent in sheltered living situations or in the amount of time spent in medical or penal institutions. The experimental patients spent significantly more time in independent settings, significantly less time unemployed, and significantly more time in sheltered employment than did control group patients. By the end of the 4 months, patients in both groups revealed a significant de-

crease in symptomatology with no significant difference between groups in amount of improvement. Preliminary measures of social relationships, leisure-time activities, quality of environment, and subjective satisfaction with life also revealed no significant differences between groups at the end of 4 months.

410. Sternlight, Manny; Siegal, Louis; and Hammond, Jack. Evaluating the retarded for community placement. *Hospital and Community Psychiatry*, 19(3): 71, 1968.

Reported is assessment of the suitability of 979 residents of a State school for the mentally retarded for some form of community placement. The evaluators considered 35 percent of the subjects suitable for community placement. When the placeable and nonplaceable patients were compared, no statistically significant differences were found between the two groups in physical development, IQ, or working versus nonworking status. However, 42 percent of the 251 placeable patients and only 14 percent of the 728 nonplaceable patients had families able to supervise them. Significantly higher percentages of the placeable subjects were rated quiet, cooperative, able to adjust to others, and honest, toilet trained, and able to feed and dress themselves. In the unplaceable group, significantly higher percentages were rated as being noisy, having tantrums, and getting into quarrels. The placeable groups consisted of 148 males and 103 females. Placement was recommended with their own families for 36 percent of the males and 20 percent of the females; in daytime community work for 28 percent of the men and 32 percent of the women; in live-in domestic work for 18 percent of the women; and in independent living arrangements for 13 percent of the males and 5 percent of the women.

411. Strauch, James D. Social contact as a variable in the expressed attitudes of normal adolescents toward EMR pupils. *Exceptional Children*, 36(7): 495–500, March 1970.

412. Stotsky, Bernard A. A controlled study of factors in the successful adjustment of mental patients to nursing homes. *American Journal of Psychiatry*, 123(10): 1243–1251, 1967.

Adjustment of ex-mental hospital patients to nursing homes is explored. There were two samples in the study: a retrospective sample of known outcomes (22 successful patients and 22 unsuccessful patients); and a prospective sample in which 65 patients in a mental hospital were evaluated prior to placement in nursing homes, 30 days after placement, and 6 months after placement. Successful adjustment was not being readmitted to a psychiatric hospital or to a psychiatric ward of a general hospital during the 6-month period following placement. A

patient was judged to have unsuccessfully adjusted if he had to return to a psychiatric hospital during the 6 months after placement or if he died in this 6-month period. Eleven homes with the greatest proportion of successful placements were compared with 11 homes with the greatest proportion of unsuccessful placements. Analysis of responses by nursing home administrators to a 111-item interview schedule revealed only one significant variable: Family members more often performed specific function in the care of patients in "successful" homes. Nurses in successful homes were significantly less authoritarian, more benevolent, and less socially restrictive in attitude, using scores from an attitude scale. A casework activity scale was developed to obtain retrospective information from caseworkers regarding followup activity with patients placed in nursing homes. Differences were not significant for any of the variables relating the impact of casework to outcome. Other social and personal factors did not prove to be significant.

413. Stotsky, Bernard A. A successful nursing home placement program. *Hospital and Community Psychiatry*, 17(11): 337-339, 1966.
414. Strickland, Conwell G. and Arrell, Vernon M. Employment of the mentally retarded. *Exceptional Children*, 34(1): 21-24, Sept. 1967.
415. Sussman, Marvin B. A policy perspective on the United States rehabilitation system. *Journal of Health and Social Behavior*, 13(2): 152-161, 1972.

    The developments and discoveries of the past decade in the area of patient rehabilitation and the changes they imply in the structure and activities of the rehabilitation system in the United States are reviewed. These developments and discoveries include several themes. The traditional model of professional-client relationships has been challenged. The family and the kin network have been reestablished as part of the therapeutic system, and the pluralism in family forms and delivery systems has been recognized. The concept of good medical care and rehabilitation as a right rather than a privilege has grown. The high financial costs of institutional care of the disabled have been established. Decentralization of the bureaucratized rehabilitation systems is proposed to make rehabilitation services readily available in the home environment of patients and their families. (30 references)
416. Swann, R.J. A survey of a boarding-home program for former mental patients. *Hospital and Community Psychiatry*, 24(7): 485-486, 1973.

417. Swanson, Robert M., and Spitzer, Stephen P. Stigma and the psychiatric patient career. *Journal of Health and Social Behavior*, 11(1): 44-51, 1970.
418. Talent, Arnold, and Keldagard, Robert E. The mentally retarded. *Federal Probation*, 39(3): 39-42, 1975.
419. Tobin, Sheldon S.; Hammerman, Jerome; and Rector, Vicki. Preferred disposition of institutionalized aged. *The Gerontologist*, 12(2, part 1): 129-133.
420. Tobin, Sheldon S. Social and health services for the future aged. *The Gerontologist*, 15(1): 32-37, 1975.

    A three-part delivery system made up of community-based organizations to prevent premature institutionalization, small long-term care institutions, and terminal care centers or hospices is hypothesized as the form of future social and health services for the elderly. Though life expectancy in the future will be about 5 years longer and people will stay healthier to a more advanced age, the elderly will probably be as incapacitated in the final phase preceding death as they are now. It is anticipated that 20 percent of the population 65 and over will need a combination of intensive and extensive social and health services. Community-based services are now being developed, but they must make a commitment to the very old and to the prevention of premature institutionalization if they are to be effective. The small, local, long-term facility is not perceived as economically feasible, though it is potentially less dehumanizing. Aged people in such an institution could be regarded as the continued responsibility of the community service agency. Costs may be limited through the use of advanced technology and paraprofessionals. Terminal-care centers in England help dying patients through the careful management of pain and maintenance of maximal social supports. Both the dying patient and the family benefit. The service forms of the future, then, may be the local provision system to prevent premature institutionalization, the community institution to humanize custodial care for the severely debilitated, and the terminal care center to help the dying person. (18 references)
421. Treger, Harvey; Thomson, Soug; and Jaeck, Gordon Sloan. A police-social work team model: Some preliminary findings and implications for system change. *Crime and Delinquency*, 20(3): 281-290, 1974.

    The Social Service Program (SSP) to provide services to individuals and families coming to the attention of police and prosecutors is described and analyzed. Each of two units included two social workers and graduate social work students. Services included social assessment, 24-hour crisis

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intervention, individual counseling, marital counseling, family group therapy, and referral to community agencies. The most prevalent offenses by juveniles referred to SSP were incorrigibility, running away, minor theft, vandalism, and drug abuse. Adults' problems included mental illness, alcohol, drug abuse, and marital, family, or emotional problems. Typical SSP clients were predominantly white males under 18 years of age, were residents of the site city, and lived with a family having an annual income of $12,000. The most frequent cause for referral to SSP was theft under $150. Most clients had no record of prior offenses. Project social workers spent from 7-9 hours, divided into 8-10 sessions, in providing direct services to the average SSP client. The average period of client activity on the project was 2.6 months. Over one-fourth of the clients were seen by project staff the same day they had contact with the police. The findings of a police-social worker attitude study show that police attitudes though initially negative became positive. (6 references)

422. Truax, Charles B.; Wargo, Donald G.; and Silber, Leon D. Effects of group psychotherapy with high accurate empathy and nonpossessive warmth upon female institutionalized delinquents. *Journal of Abnormal Psychology*, 71(4): 267-274, 1966.

Behavioral or personality changes in institutionalized delinquent girls receiving group psychotherapy is compared to changes in delinquent girls receiving no psychotherapy. The girls were randomly assigned to therapy (40) or control (30) conditions from a total population of 70 available female inmates at an institution. The time-limited group psychotherapy was led by therapists offering high accurate empathy and nonpossessive warmth; four groups of 10 girls were conducted. Therapy had the effect of helping delinquent girls stay out of institutions in the year following the study and of reducing delinquency-prone behavior. A major mediating effect of therapy was to change self-concept in a positive direction, increasing the congruence between the self and the ideal self, and to change the delinquent's attitudes toward parents and siblings in a positive direction. (24 references)

423. Turbow, Sandra B. Geriatric group day care and its effects on independent living. *The Gerontologist*, 15(6): 508-510, 1975.

424. Vacc, Nicholas A. A study of emotionally disturbed children in regular and special classes. *Exceptional Children*, 35(3): 197-204, 1968.

The changes in academic achievement and overt behavior of emotionally disturbed children in special classes are compared

with emotionally disturbed children in regular classes, and the social position of emotionally disturbed and normal children is assessed. A group of 16 emotionally disturbed children attending regular classes was matched with 16 children in special classes. The Wide Range Achievement Test and the Behavior Rating Scale were administered at the beginning and end of the school year to the emotionally disturbed children in regular and special classes. Mean gain in grade achievement was .56 for experimentals versus .30 for controls. On the Behavior Rating, mean gain in grade achievement was .42 for experimentals versus .24 for controls. Sociometric data indicated that emotionally disturbed children in regular classes were significantly less well accepted than normal children. (30 references)

425. Vacc, Nicholas A. Long term effects of special class intervention for emotionally disturbed children. *Exceptional Children*, 39(1): 15-22, 1972.

The long-term changes in achievement and overt behavior of emotionally handicapped children who had experienced special class placement and who had returned to regular classes for at least 2 years are compared with those emotionally handicapped children who had not experienced the special class procedure. A group of 16 emotionally disturbed children attending public schools in the centralized district of Chautauqua County, New York, was matched with members of two special classes, each containing eight emotionally disturbed children. The groups were administered the Wide Range Achievement Test and Behavior Ratings Scale at entry, at the end of the school year, and after 5 years and 8 months. A comparison of test data at the time of entry and at the end of the school year for the two groups indicated greater gains by special class children in all the areas tested. But these same comparisons, using the data collected on the 5-year, 8-month followup, indicate that special classes do not result in long-term changes for emotionally disturbed children as compared to emotionally disturbed children placed in regular classes. No significant gains were made by the special class group in either achievement or overt behavior. It is concluded that if special classes have any advantages over regular classes for emotionally disturbed children, it exists only as long as the children remain in the special program. (19 references)

426. Vasoli, Robert H., and Fahey, Frank J. Halfway house for reformatory releasees. *Crime and Delinquency*, 16(3): 292-304, 1970.

Described is the Notre Dame Youth Center (NDYC) in

Gary, Indiana, which collaborated with Inland Steel Company in a halfway house program which emphasized vocational rehabilitation for youthful reformatory parolees. Participants were drawn from the 18- to 25-year-old inmate population at the State Reformatory. Inland Steel Company agreed to accept for employment up to 15 releasees per month if they were healthy, had an IQ of 90 or more, and had a 10th grade education or its equivalent. Those accepted were assigned to a specific job and shift by Inland's personnel department. The lowest skill level job paid $2.60 hourly. The NDYC was located in a hotel in Gary, where each youth was given free shelter for at least 6 weeks and a $38 weekly allowance until his first paycheck. Some inmates who failed to qualify for Inland were accepted at NDYC, which attempted to find employment for them. Staff included a director, a project supervisor who handled job placement, and three resident counselors. The program included recreation, supervision and guidance, psychological testing and counseling, medical care, and education. During the program's single year of operation, 77 parolees participated, 50 of whom were hired by Inland. Each participant was gainfully employed at one time or another. Sixteen participants (21 percent) recidivated. Those who worked at Inland had the same rate of recidivism as those rejected. (8 references)

427. Villeponteaux, Lorenz. Crisis intervention in a day school for delinquents. *Crime and Delinquency*, 16(3): 317-323, 1970.

428. Wagenfeld, Morton O. The primary prevention of mental illness: A sociological perspective. *Journal of Health and Social Behavior*, 13(2): 195-203, 1972.

The movement for primary prevention of mental illness is criticized. Crucial for primary prevention is the notion that mental illness is etiologically or sequentially associated with such social conditions as poverty and racism. There is no evidence for causal linkages between poverty and mental illness, since studies have not clearly supported an etiological link between the two. The evidence supporting an inverse relationship between socioeconomic status and mental disorder is powerful, but there are a number of difficulties in conceptualization and method. The imputation of any direct causal link between poverty and mental illness cannot safely be maintained. It is suggested that primary prevention rests on an ideological, rather than empirical, foundation.

429. Wagenfeld, Mortion O.; Robin, Stanley S.; and Jones, James D. Structural and professional correlates of ideologies of community mental health workers. *Journal of Health and Social Behavior*, 15(3):199-210, 1974.

430. Wagenfeld, Morton O.; Turner, R. Jay; and Labreche, Gary. Social relations and community tenure in schizophrenia. *Archives of General Psychiatry*, 17(4): 428–434, 1967.

The extent to which social relations are related to community tenure is explored for a random sample of 214 white male schizophrenics, age 20 to 50, who were recorded to have had some kind of psychiatric contacts in Monroe County (New York) between January 1, 1960 and June 30, 1963. Patients having psychiatric hospitalization prior to the initial contact during this period were excluded. Social relations were defined as including only involvement or interaction with others in leisure activities, contact with relatives, and participation in voluntary associations. The correlation between level of social relations and amount of time in hospital was .274 (p 0.0005). Except for a slight reversal in the last two categories, the mean hospitalization decreased with increasing amounts of social relations. When level of pathology, social class, and living situation were controlled, the degree of involvement in social relations was highly related to severity of pathology. The relationship between the summary score of social relations and time in hospital, with the effects of pathology extracted, was still statistically significant. A similar analysis controlling both pathology and class indicated that social relations were still correlated to time spent in hospital. Social relations varied significantly by living situation, with those in families of procreation having the highest degree of involvement. Data sources were psychiatric case register and independent ratings by psychiatrists, questionnaire, and social worker's interviews.

431. Waldman, Arthur; Ward, Morton; and Yaffee, Silvia. Periodic health examinations and mortality in the elderly. *International Journal of Aging and Human Development*, 1(4): 323–332, 1970.

Presented is an evaluation of preventive medicine for the elderly, i.e., periodic health appraisals and accessibility of care with respect to survival. An experimental group received regular physical exams and had access to full medical care. A control group of similar people did not have assured periodic exams nor proximity to care. The study was continued for 4 years, after which mortality rates in both groups were compared. The experimental group was made up of 200 elderly people (76 male, 124 female) living semi-independently in an apartment house setting, with median age 79. The control group consisted of 200 elderly (78 male, 122 female) from the community with a median age of 75 and range of 62 to 91. The groups were comparable in age, socioeconomic status, and

ethnicity. Both groups were examined at the beginning of the study. The examination included a complete history and physical exam, including cardiopulmonary, urinalysis, blood, ocular tension, vision, and hearing tests. The experimental group was given a yearly exam for 3 subsequent years and received regular medical treatment at the housing site. Communication with the control group was maintained by mail and consisted of questions regarding any illness or hospitalization. Both groups were examined at the end of the 4th year. These procedures brought many persons with significant but unrecognized diseases under medical supervision. At the end of the study, 29 percent of the experimental and 22 percent of the control group were deceased. Since many differences between the control and experimental groups in relevant factors had become apparent, subgroups of subjects were matched on the basis of age, sex, and physical classification. Among 108 matched pairs, 26 percent of the experimental and 18 percent of the control subjects had died. There is no support, then, to the notion that regular exams and proximity to care affect mortality. There may have been uncontrolled differences between the experimental and control groups associated with their different living arrangements; in any case, these results do not support periodical medical exams. (14 references)

432. Walker, Valaida Smith. The efficacy of the resource room for educating retarded children. *Exceptional Children*, 40(4): 288-289, Jan. 1974.

The efficacy of a resource room program as an alternative educational strategy to special self-contained classrooms for children diagnosed and labeled as "educable mentally retarded" is examined. An experimental group was assigned to regular classes and received academic instruction as needed in a resource room by a special education teacher. Three control schools were selected to match three experimental schools in pupil population, racial composition, socioeconomic status, and geographic location within the Philadelphia public school system. A control group (41) and an experimental group (29) of children were matched on chronological age, IQ, and reading level. The children were administered the Bristol Social Adjustment Guides and three subtests of the Stanford Achievement Test at the beginning and at the end of the 1971-1972 school year. Analysis of variance of change data found no significant differences in self-concept, social adjustment, or arithmetic. Children in the resource-room program, however, were significantly better academically and socially at each testing in the areas of word reading and vocabulary. (4 references)

433. Walker W. Ray; Parsons, Lowel B.; and Skelton, W. Douglas. Brief hospitalization on a crisis service: A study of patients and treatment variables. *American Journal of Psychiatry*, 130(8): 896-900, 1973.

434. Warfield, Grace J. Mothers of retarded children review a parent education program. *Exceptional Children*, 41(8): 559-562, 1975.

435. Warner, Frank; Thrapp, Robert; and Walsh, Suzanne. Attitudes of children toward their special class placement. *Exceptional Children*, 40(1): 37-38, Sept. 1973.

436. Warren, Marguerite O. The case for differential treatment of delinquents. *Annals of the American Academy of Political and Social Science*, 381: (57-59) 1969.

437. Weinstein, Laura. Project re-ed schools for emotionally disturbed children: Effectiveness as viewed by referring agencies, parents and teachers. *Exceptional Children*, 35(9): 703-711, 1969.

438. Wetter, Jack. Parent attitudes toward learning disability. *Exceptional Children*, 38(6): 490-491, 1972.

439. White, Benjamin D., and Beattie, Ella J. Day care for the mentally retarded as a part of local health services in Maryland. *American Journal of Public Health*, 56(11): 1883-1890, 1966.

440. White, W.D. Jr.; McAdoo, William George; and Phillips, Leslie. Social competence and outcome of hospitalization: A preliminary report. *Journal of Health and Social Behavior*, 15(3): 261-266, 1974.

A report is presented seeking change factors associated with social competence among mental patients and their effectiveness in adapting to the community after release from the hospital. The Worcester Scale of Social Competence was used to measure level of social adequacy as reflected in educational and occupation achievement, work history, organizational participation, use of leisure time, marital status, and living arrangements. The Worcester Scale was administered to 159 patients in a State hospital early in their hospitalization and again 1 year following discharge. Pre- to post-hospitalization change scores were related to other factors by means of a Wilcoxan matched pairs signed-rank test. The analysis revealed significant sex differences with regard to role orientation and the adequacy with which leisure time is utilized. Data also indicated a shift in lifestyle, more prominent in male expatients, from a physically active, outwardly oriented role to one characterized by passivity and an inwardly oriented role.

441. Whitman, Pearl S., and Oppenheimer, Sonya. Locating and treating the mentally retarded. *Social Work*, 11(2): 44-61, 1966.

442. Whittington, H.G., and Steenbarger, Charles. Preliminary evaluation of a decentralized community mental health clinic. *American Journal of Public Health*, 60(1): 64-77, 1970.

443. Wiernasz, Michael J. Quarter-way-house program for the hospitalized mentally ill. *Social Work*, 17(6): 72-77, 1972.

Described is a quarterway-house program using a social group work approach to resocialize and remotivate long-term patients of a State mental hospital in Connecticut. The short-term goals of the program were to raise patients' levels of functioning and prepare them to return to the community. Long-term goals were to increase discharges and reduce recidivism. The staff included a registered nurse, two social workers, and student volunteers. Preference was given to patients who had been hospitalized for several years and were ambulatory and able to assume responsibility for medication. Patients committed by the court if diagnosed as alcoholic, drug dependent, suicidal, or homicidal were excluded. For participation in chores and therapy, residents were given vouchers redeemable for 25 cents or a package of cigarettes. Alterations in house rules, expenditures of money, and transfer or discharge of residents required the residents' sanction as a group in daily meetings. Daily activity groups ranged from structured games to informal trips into the community, therapy groups to deal with fears and adjustment problems, special interest groups, and a self-help group. Residents considered ready to enter the community joined placement groups to discuss their feelings about being discharged and to participate actively in the decision about their release. Between June 1969 and August 31, 1971, 173 patients (130 males and 43 females) who had been hospitalized for 5 to 45 years participated in the program. As of October 1971, 21 had returned to the hospital. Over 50 percent of the discharged residents were placed in aftercare facilities, about 26 percent established independent living situations, and the remainder lived with relatives or friends.

444. Wilder, Jack F.; Kessel, Marie; and Caulfield, Stephen C. Follow-up of a "high expectations" halfway house. *American Journal of Psychiatry*, 124(8): 1085-1091, 1968.

Adjustment to community is studied among young ex-mental hospital patients who experience an intensive transitional residential program. Subjects were 20 men and 22 women residents of a halfway house program in which residents are expected to assume primary responsibility for meals, budgeting, cleaning, laundering, and activity programs. The median

age of the women was 22 and of the men, 26. Approximately 90 percent were white, and nearly 90 percent were single. Clinically, 77 percent had been diagnosed as schizophrenic reaction. Forty of 42 had a history of psychiatric hospitalization, nearly 70 percent coming from a hospital. The clinical, vocational, and social course of each resident during their stay in the halfway house and the 6-month period after departure from the halfway house are rated. Global assessments covering community tenure, course of employment, and independent living arrangement divided the residents into two groups, Successes and Failures. The most striking difference between the Success and Failure groups was in the ability to gain employment quickly. The older, better motivated, more employable residents did best in this adult, high-expectations setting.

445. Wilkinson, Gregg S. Interaction patterns and staff response to psychiatric innovations. *Journal of Health and Social Behavior*, 14(4): 323-329, 1973.

446. Wolkon, George H. Characteristics of clients and continuity of care in the community. *Community Mental Health*, 6(3): 215-221, 1970

Reported is an exploratory analysis of utilization of rehabilitation aftercare services by mental patients. Data came from interviews and the hospital records of 312 patients referred to a community based social rehabilitation center from three State-supported psychiatric hospitals. Demographic, personal, and psychiatric data on patients, measures of ego strength, and role expectations were correlated with patients' utilization of service. The patients were between the ages of 20 and 60, with a mean age of 36.5. The mean length of current hospitalization was 5.7 months. Three-quarters of the patients had a diagnosis of some form of schizophrenia. It was striking that 204 of the 312 patients chose not to follow through on the referral; i.e., they did not attend the program at least twice after their release. Of the persons who began the program, only half attended more than 10 times. Sex, race, religion, education, and age were not related to beginning or continuing in the rehabilitation program. Being single, divorced, or widowed was significantly related to beginning in the program, but not to continuing. Persons receiving financial support from public agencies began the program significantly more often than those persons not receiving government funds. Duration of last hospitalization and type of hospital release were significantly related to beginning, but not to continuing in the program. Two measures of ego strength obtained during the

research interview were not related to either beginning or continuing in the rehabilitation program. Nearly all measures of role expectation were not significantly related to beginning or continuing in the rehabilitative program. The amount of change expected by the patient in the year following hospital release in social participation and task-role performance, while not related to beginning the program, was significantly related to continuing in the program. Dependency may be the differentiating factor between participants and nonparticipants in the program.

447. Wolkon, George H., and Tanaka, Henry T. Outcome of a social rehabilitation service for released psychiatric patients: A descriptive study. *Social Work*, 11(2): 53-61, 1966.

A description of a followup study of persons referred to a social rehabilitation center for recently released psychiatric patients is presented. The 166 subjects of the study were between 20 and 60 years of age and had been out of the hospital for at least 1 year. Each had been hospitalized for at least 1 month and was not in the community more than 4 months before becoming active at the rehabilitation center. Half the subjects were male; 77 percent were white and the remainder black. Thirty percent were between 20 and 29 years of age, 33 percent between 30 and 39, and the remainder between 40 and 60. Single persons comprised 54 percent of the sample, married persons 20 percent, and separated, divorced, or widowed 25 percent. One hundred forty-one were diagnosed schizophrenics, and the rest had functional disorders. The rehabilitation center was a nonresidential, transitional facility designed to help ex-patients achieve independent living. Group work was the main therapeutic modality. Participation in the program was limited to 1 year. Attendance records were kept. Of the 166 persons, 51 percent left the program against staff advice, 22 percent remained 1 year, 19 percent refused services after intake, 11 percent were rehospitalized while still active in the program, and 7 percent were still active in the program. A followup study of 118 former members of the rehabilitation center, out of the hospital a year or more, was conducted. Six months after program termination, 29 percent of the ex-members were rehospitalized; after 1 year, 38 percent; and after 18 months, 53 percent. Forty-five percent of the 58 persons who attended 25 or fewer times were rehospitalized within 1 year after membership termination; 22 percent of the 23 persons who attended more than 25 times were hospitalized ($X^2 = 3.72$, $p < .06$). For the 24 ex-members, who the staff agreed had achieved maximum benefit from the program, there was a 4 percent rehospitalization rate

within 1 year after termination. For the 46 members who terminated against staff advice, 30 percent returned to the hospital within 1 year after termination ($X^2 = 6.46$, $p < .02$).

448. Wood, Roland W. Major Federal and State narcotics programs and legislation. *Crime and Delinquency*, 16(1): 36-56, 1970.

Changes in legislation and public attitudes toward drug addicts and addiction are reviewed, concentrating on the 1966 Federal program and State programs in New York, California, New Jersey, and Illinois. The Federal Narcotic Addict Rehabilitation Act of 1966 allowed the court to hold criminal charges in abeyance if the drug abuser submitted to a medical exam to determine if he was an addict. If found to be an addict, he was civilly committed to the Surgeon General for treatment. Minimum and maximum times for such commitment were stipulated in the Act. The Act authorized assistance to States to develop their own programs; however, the Bureau of the Budget did not fully fund the program. By January 1968, 385 addicts had been placed in aftercare programs. New York embarked on the most comprehensive addiction treatment program. Forty 200-man treatment centers were planned. By the end of 1968, 7,492 addicts were receiving care. Figures showed that 44 percent had not resumed drug use and 30 percent had and were returned to a rehabilitation center. The other 26 percent could not be located, and warrants were issued for them. California had several interlocking programs administered by the Director of Corrections. There was a Narcotic Treatment Control Project to treat parolees and a Civil Addict Program to civilly commit addicts. The California effort included private and governmental local programs and special parole programs. New Jersey's programing, which began in 1964, used a mental hygiene model which did not include civil commitment. A large number of addicts have left the program against medical advice. Counties are not urged to establish aftercare clinics. In 1967, Illinois passed the Drug Addiction Act, which combined all treatment concepts. A pilot program began in 1968 to test several different treatment modalities to which applicants were randomly assigned. Participants were evaluated weekly. By March 1969, 265 patients were in treatment. Generally, these new programs and changing public policy have reversed the punitive trends of the courts. Treatment has been substituted for custodial care. The addict has been redefined as a person who is ill, incapacitated, and in need of treatment. (47 references)

449. Woodbury, Michael A., and Woodbury, Margarita M. Community-centered psychiatric intervention: A pilot project in

the 13th arrondissement, Paris. *American Journal of Psychiatry*, 126(5): 619–625, 1969.

450. Wooden, Kenneth. *Weeping in the Playtime of Others*. New York: McGraw-Hill, 1976.

An indictment of the long-term care system in the United States for dependent, disturbed, and delinquent youth is presented, with documentation in the form of many case examples. The dehumanized and dreary nature of most long-term care is described, along with many examples of abuse, brutalization, and profiteering. In the last two chapters, alternative forms of care are outlined, and a reform strategy is suggested. Some 20 child-service or child-care programs are noted which have avoided the dehumanization, costliness, and endlessness of most care situations. Several characteristics of these case examples are noted. Each has one imaginative and energetic individual to lead it. Most of these programs are willing to take on children considered very difficult. Third, emphasis is placed on making a child face his or her own problems realistically. Finally, either the child's blood family or a group of family-like supporting persons are mobilized to help development of the child. These 20 or so projects were found to be only one-third as costly as typical programs, but much more effective in getting children out of treatment and in preventing recidivism. In the final chapter, an advocacy strategy is suggested for reforming long-term care of children which includes four elements: investigation, coalition-formation, issue promotion, and legal action.

451. Zahn, Margaret A. Incapacity, impotence and invisible impairment: Their effects upon interpersonal relations. *Journal of Health and Social Behavior*, 14(2): 115–123, 1973.

The influence of an impairment's severity, functional limitations, and visibility on a person's interpersonal relations with his spouse, family, friends, and others is assessed. A sample (2,454) was randomly drawn from applicants for disability benefits in New Orleans, Minneapolis-St. Paul, and Columbus, Ohio. Structured interview schedules, narrative reports, and laboratory tests were used to gather information regarding the applicant's relationship with his spouse, friends, and others and his view as to the effect of his handicap on his interpersonal relations. A contingency analysis of these data including Chi-square tests indicated that functional limitations in communication, work, and sexual capacities do make a difference in the interpersonal relations between the physically impaired and the nonimpaired. The functional limitations that seem most problematic are those that create an ambiguous status for the person or hamper his ability to clarify

his status. Visibility of impairment also affects the interpersonal relations of the impaired.

452. Zalba, Serapio R. Work-release: A two-pronged effort. *Crime and Delinquency*, 13(4): 506-512, 1967.

Successful work-release programs for prison inmates in Wisconsin and California are described and analyzed. Such programs provided some needed institutional control while giving the opportunity to perform in socially desired roles in the community. Most programs were for misdemeanants sentenced to county jails. The misdemeanant could be committed to the program by the judge, or by the county parole board, or automatically eligible for it in Wisconsin if sentenced to "hard labor." If the inmate already had a job, he continued his employment. If he had no job, an attempt was made to find one for him. Payment was in accord with current rates; the average wage in Wisconsin is $20 per day. Workers had the right to quit a job if they felt exploited. Earnings were usually disbursed among partial cost of room and board, family support, personal expenses, and savings, with family support the major item. The amount charged by the County for room and board varies. In Wisconsin, work-release earned $2.8 million from 1955-1960, with $633,000 in 1960. In Marin County, California, the annual average for years 1959-1965 was $46,000. The annual average in Orange County, California for years 1962-1964 was $122,000. Escape rates vary from 1 percent to 12 percent. An unexpected outcome of these work-release programs is that as judges become more aware of the practicability of releasing offenders under supervision, they have placed larger numbers directly on probation rather than committing them to jail. (12 references)

453. Zeeman, Roger, and Martucci, Irene. The application of classroom meetings to special education. *Exceptional Children*, 42(8): 461-462, May 1976.

454. Ziegler, Suzanne, and Hambleton, Donald. Integration of young TMR children into a regular elementary school. *Exceptional Children*, 42(8): 459-461, May 1976.

455. Zimberg, Sheldon. Outpatient geriatric psychiatry in an urban ghetto with nonprofessional workers. *American Journal of Psychiatry*, 125(12): 1197-1207, 1969.

U.S. GOVERNMENT PRINTING OFFICE : 1980 O - 319-674